

**Previous Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Doctor’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Doctor,

This patient now attends Moreland General Practice. Could you please forward all his/her relevant clinical details to myself at your earliest convenience.

Moreland General Practice has only electronic patient records. If your practice has the facility to forward on a disk, can we please request it be sent as an **xml format and when exporting please tick the “entire file”**

Please find below an authority signed by the patient, giving consent for this information to be supplied by you.

Yours sincerely,

Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_**

# ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PERMISSION TO OBTAIN MEDICAL RECORDS

I hereby give permission for Moreland General Practice to obtain my medical records from your Practice.

# SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Dr. C. Matheson  | 521826CL |
| Dr. C. Glover | 5090372W |
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| --- | --- | --- | --- | --- | --- |
| Dr.T.Ahern | 011884EJ | Dr.J.Erlich | 058347GT | Dr.E.Bond | 4336606W |
| Dr.M.Levick | 0575756W | Dr.I.Bonwick | 0417165J | Dr.T.Zucarello | 4336017F |
|  |  | Dr.C.Stewart | 047318DY | Dr Ellwood-Shoesmith | 419987BK |
|  |  | Dr.A.Innes | 2429886J | Dr.I.Bush | 475162AY |
|  |  | Dr.P.Carey | 058785CX | Dr. L. Rinaudo  | 5059149F |

