HAMILTON MEDICAL CENTRE

Dr Piotr Michalski | 2520456F **Dr Ella Hegarty | 5205491W**
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Medical Records Transfer Request

SECTION 1 – STAFF TO COMPLETE

Dear Doctor,

The following patient(s) have requested for their previous medical records to be transferred to Hamilton Medical Centre for future care.
Please send ***only a health summary***, as we are a paperless practice and have limited storage space. We use ***Best Practice*** so please only send a disc if downloaded from this program.
Please indicate the billing date of services listed below, and if applicable, we kindly ask for copies of relevant care plans so that we comply with Medicare standards when reviewing these plans.

GPMP 721	Date Performed:	Diabetes Cycle of Care	Date Performed:
TCA 723	Date Performed:	Asthma Cycle of Care	Date Performed:
> 75 H/A	Date Performed:	45-49 Health Check	Date Performed:
GP MHCP 2701,2700,2715,2717	Date Performed:	Medication Rev. (900)	Date Performed:
GP MHCP Rev. 2712	Date Performed:	GPMP Review (732)	Date Performed:

Special Requests: _____
_____

SECTION 2 - PATIENT TO COMPLETE

Previous Doctor Details

Doctor Name:			
Practice Name:			
Practice Address:	**Suburb:**	**State:**	**Post Code:**
Practice Ph:			
Practice Fax:			

Patient Details

Patient Name:			
Patient DOB:			
Current Address:	**Suburb:**	**State:**	**Post Code:**
Previous Address: (if applicable)	**Suburb:**	**State:**	**Post Code:**
Patient Signature:			**Date:**

I do hereby authorise the release of records for my children/dependents as listed below: (must be under 18)

Name:		**DOB:**
Name:		**DOB:**
Name:		**DOB:**
Name:		**DOB:**