Medical Records Transfer Request Form

Please forward the below completed form to:

North Fitzroy Medical Centre

460 Brunswick Street

Fitzroy North VIC 3068

Dear Doctor / Practice: _____

Address: _____

Fax/Email: _____

Patient Name	DOB	Signature

By signing this form, I _____authorise you to release confidential health information about me to the doctor / practice mentioned below, who is now responsible for my ongoing care.

Signature:

Date:

Please do not send the records via printed copies and fax. We accept XML in a CD as we are using Best Practice. If you have any troubles with this type or transfer, please contact us.