Transfer of Medical Records Form

Welcome to Vitalis Healthcare. We are committed to providing our patients with the best care.
To do this it is essential that your health record is kept up to date and accurate.

I, ____,
hereby authorise and request that you transfer a copy of all records in your possession concerning any diagnosis, prognosis and recommendation, as well as other data pertinent to your treatment of the patient named bleow.

PATIENT INFORMATION

PATIENT PERSONAL DETAILS

First name:	Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:
Middle name:	Preferred name:
Last name:	Date of birth: _ _ / _ _ / _ _ _ _

PATIENT ADDRESS

Street:	City/Suburb:	Postcode:

PATIENT PHONE NUMBER(S)

Phone:	Mobile:

TRANSFERRING FROM

DOCTOR DETAILS

Name: Dr

MAILING ADDRESS

Street:	City/Suburb:	Postcode:

PHONE AND FACSIMILE NUMBER

Phone:	Facsimile:

EMAIL ADDRESS

Email:

SIGNATURE PATIENT / GUARDIAN	DATE

Please forward patient files via:

- Email - reception@vitalishealthcare.com.au
- CD (Best Practice)
- Fax - 02 8123 1134
- Post - Vitalis Family Medical Practice, 550 Princes Highway - Kirrawee NSW 2232