Googong Family Practice

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Googong NSW 2620
admin@googongfp.com.au
Ph 02 5104 9595
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Practice Doctor
Practice Name
Practice Address

Dear Doctor,

Re: Request for transfer of patient medical records

The patient/s listed below has requested a copy of their medical record be sent to our clinic. Please forward a copy of their medical record/s (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient 1		Date of Birth
Patient 2 :		Date of Birth
Patient 3		Date of Birth
Patient 4		Date of Birth
Patient 5		Date of Birth

Please complete additional forms if more space is needed

Patient consent

I, _____consent to the release of my medical records and any other relevant clinical information to **Googong Family Practice**.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing – name: (please print) _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) _____

NB: All patients 16 years and older must sign themselves

If sending the records electronically, it would be appreciated if they were sent in **.xml** format.

Yours sincerely,

Googong Family Practice.