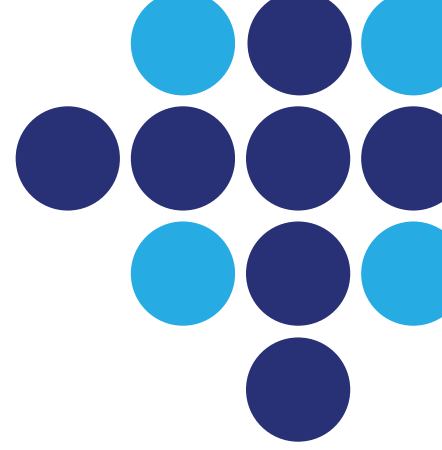


BALWYN CENTRAL MEDICAL



I, _____ give
consent for my medical records to be released to Balwyn
Central Medical, 427 Whitehorse Road, Balwyn VIC 3103

Patient Date Of Birth:

Patient Address:

Patient's previous clinic/GP:

Phone: _____

Fax: _____

Patient signature:

Date: _____

Please include the following:

- | | | | |
|--------------------------|-----------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | Health Summary | <input type="checkbox"/> | Immunisation History |
| <input type="checkbox"/> | Health Assessment | <input type="checkbox"/> | Visit Notes |
| <input type="checkbox"/> | GP Care Plan (721) | <input type="checkbox"/> | Specialist Letters |
| <input type="checkbox"/> | Team Care Arrangement (723) | <input type="checkbox"/> | All Existing Records |
| <input type="checkbox"/> | Investigation Reports | | |

I authorise for this release to be:

- Faxed to the requested practice
 Sent by mail to the requesting practice

If sending by CD, format must be in XML

OFFICE USE ONLY

Date copy sent: _____

Signature of Practice Representative: _____

TRANSFER OF MEDICAL RECORDS FORM