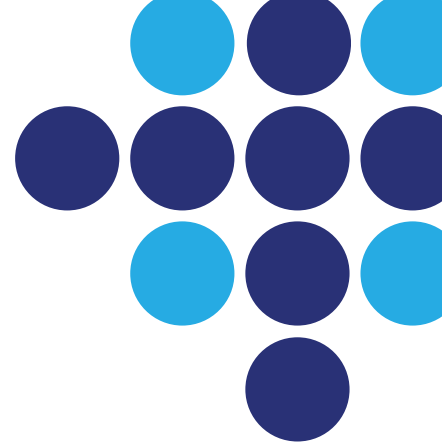


# BALWYN CENTRAL MEDICAL



I, \_\_\_\_\_ give  
consent for my medical records to be released to Balwyn  
Central Medical, 427 & 411 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

\_\_\_\_\_

TRANSFER OF MEDICAL RECORDS FORM

## OFFICE USE ONLY

Date copy sent: \_\_\_\_\_

Signature of Practice Representative: \_\_\_\_\_