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:

- ☐ Health Summary
- ☐ Health Assessment
- ☐ GP Care Plan (721)
- ☐ Team Care Arrangement (723)
- ☐ Investigation Reports
- ☐ Immunisation History
- ☐ Visit Notes
- ☐ Specialist Letters
- ☐ All Existing Records

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

HEALTH GROUP

427 & 411 Whitehorse Rd,
Balwyn VIC 3103

P: (+61) 3 9830 2300
F: (+61) 3 9830 2355
bcmedical.com.au