Alkimos Family Practice
Shop 2/15 Graceful Blvd
Alkimos WA 6038
Phone: 08 9548 9201
Fax: 08 6185 2990
ABN: 24 683 822 540

MEDICAL RECORDS REQUEST FORM

Date:

PREVIOUS PRACTICE DETAILS

Name of Previous Practice:

Phone Number:

Fax Number:

Email Address:

PATIENT DETAILS

Patient Full Name:

Date of Birth:

Address:

Dear Doctor,

Re: Request for transfer of patient medical records as the above patient now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Our preferred method of receiving files is in .xml format and/or via HealthLink EDI - warwmcsc

PATIENT DECLARATION: I consent to the release of my medical records and any other relevant clinical information to Warwick Medical Centre and Skin Clinic.

Patient name: ____

Signature: ____Date: _____________________________

Parent/Guardian Name (if under 16): (please print) ____

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