HEATHMONT HEALTHCARE CENTRE
Your Partner in Health

A: 44 Canterbury Road, Heathmont VIC 3135
T: 03 9124 3893
F: 03 9124 3894
E: info@heathmonthealthcare.com.au
W: www.heathmontheathcare.com.au

Medical Records Transfer Request Form

Please forward the below completed form to:

Heathmont Healthcare Centre

44 Canterbury Road

Heathmont, VIC 3135

Dear Doctor / Practice: _____

Address: _____

Fax/Email: _____

Patient Name	DOB	Signature

By signing this form, I _____authorise you to release confidential health information about me to the doctor / practice mentioned below, who is now responsible for my ongoing care.

Signature:

Date:

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Please do not send the records via printed copies and fax. We accept XML in a CD as we are using Best Practice. If you have any troubles with this type or transfer, please contact us.