TRINITY CARE
FAMILY PRACTICE

Request for Transfer of Records

Doctor: _____

Practice Name: _____

Phone: _____ Fax: _____

Dear Dr,

We wish to advise you that the following patient(s) are now attending this medical practice and would like to have his/her/their medical records transferred. We would appreciate if you could send any relevant information to assist with their continuing care.

If you practice uses Best Practice software, we would appreciate if you could export the files onto disc or USB via XML format. Thank you.

Doctor Requesting:

- ☐ Dr Chee Teh
- ☐ Dr Debbie Hsieh
- ☐ Dr Lawrie McArthur
- ☐ Dr Lesley Blimkie
- ☐ Dr Karim Khan

Please forward the following:

- ☐ Complete Record
- ☐ Care Plan / TCA
- ☐ Mental Health
- ☐ Specialist Letter(s)
- ☐ Procedural – Spirometry, ECG
- ☐ Pathology
- ☐ Radiology
- ☐ Other: _____

I hereby authorise the release of my/our medical records to Trinity Care Family Practice.

Patient Name: _____ DOB: _____

Address: _____

Patient/Guardian Signature: _____ Date: _____

Other member(s) of my family:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____