PO Box 975 BAIRNSDALE, VIC 3875
Phone: 03 5152 3500 Fax: 03 5152 3966
reception1@advantagehealthpoint.com.au

REQUEST FOR MEDICAL RECORD TRANSFER

PREVIOUS DOCTOR:	
PREVIOUS CLINIC NAME:	
CLINIC ADDRESS:	
CLINIC PHONE:	CLINIC FAX:

PATIENT NAME:
PATIENT CURRENT ADDRESS:
PATIENT FORMER ADDRESS:
PATIENT DATE OF BIRTH: / /

PLEASE TRANSFER HISTORY OF FOLLOWING CHILDREN/UNDERAGE DEPENDANTS:

NAME:	D.O.B / /
NAME:	D.O.B / /
NAME:	D.O.B / /
NAME:	D.O.B / /

The above patient/s, whose signature appears below, is now attending Advantage HealthPoint.
Would you kindly forward the clinical record in XML electronic format or hardcopy via mail.
If this is not possible, as a minimum, please forward the following:

- An accurate, updated health summary
- Results of the most recent set of routine screening tests (as per RACGP guidelines)
- All specialist correspondence
- All imaging reports

PLEASE CONTACT THE PATIENT DIRECTLY IF YOU REQUIRE PAYMENT FOR THE TRANSFER OF THESE RECORDS.

I hereby give authority for a copy of my medical history and the medical history of the above listed dependants, to be released to Advantage HealthPoint.

Signed: Date: