STEPHENSONS
MEDICAL CENTRE
ABN: 49 554 546 009

247 Stephensons Road,
Mount Waverley Vic 3149
Ph: 03 9888 1818
Fax: 03 9888 1816

Request for Medical Records Transfer

Dr. .....

Address .....

Suburb ..... State ..... Post Code .....

Ph: ..... Fax: .....

Dear Dr

Patient Full Name	Address	DOB

Other Family Members (if under 18 years of age.)	Address	DOB

The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward (Please do not send original documents)

- ☐ Their clinical records
- ☐ An accurate health summary, with relevant correspondence and results,
- ☐ Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP)

These records can be forwarded by mail, fax, Non rewritable CD. Electronic format in **XML**

Yours sincerely

Doctor ..... ☐ **Dr Michael Zheng** ☐ **Dr Johnsons Hsu**

PATIENT'S SIGNED AUTHORITY

I ..... {Patients full name}

Of .....

{Patients current address and date of birth}

Formerly of .....

{Patients former address if applicable}

Authorize the release of my/my families' medical records to be forwarded to **Stephensons Medical Centre**

Signed: ..... Date: .....