1 Homewood Street
Cloverdale WA 6105
Fax: 08 9277 8608 **Ph: 08 9277 8688**

REQUEST FOR MEDICAL RECORDS TRANSFER

To Whom It May Concern

Please arrange for the transfer of medical records as authorised below.

Patient: Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other ___________________________

First Name _______________________ Middle Name ___________________________

Last Name _______________________ Date of Birth ___ /___ /____

Home Address ________________________________ State ______ Postcode ________

Name of dependants (under 18 years of age) to be included in medical record transfer:

Name _____________________________ DOB ________________

Name _____________________________ DOB ________________

Name _____________________________ DOB ________________

To further assist with correctly claiming Medicare Item Numbers could you please kindly supply the last billing date of the following item numbers –

ITEM	Date Last Billed	ITEM	Date Last Billed
701-703-705-707 HA	__/__/___	900 HMR	__/__/___
721 GPMP	__/__/___	2715 MHP	__/__/___
723 TCA	__/__/___	2717 MHP	__/__/___

Patient Authorisation: I hereby authorise

Dr/ Practice name ____

Address ___________________________________ State _____ Postcode ______

Fax Number _______________________

to release copies of my medical records to

Fulham GP
1 Homewood Street
Cloverdale WA 6105

Please kindly send via .xml format, on non-rewritable CD or USB.

Signed (Parent / Guardian) _________________________ Date ___ /___ /____