Vita Medical and Skin Clinic
Shop 4, 264 Pinjarra Road
Mandurah WA 6210
Tel: (08) 6400 6630
Fax: (08) 6234 1167
Email: info@vitamedical.au
ABN: 12 654 082 952

MEDICAL RECORDS TRANSFER REQUEST

I____ give consent for my medical records to be released to:
(PRINT NAME CLEARLY)

VITA MEDICAL AND SKIN CLINIC 4/264 Pinjarra Road, Mandurah WA 6210

Tel: (08) 6400 6630 Fax: (08) 6234 1167 Email: **info@vitamedical.au**

Patient D.O.B: ______ / ______ / ________ Patient Contact Phone: _____________________________

Patient Address: ____

Patient's previous clinic/GP: ____

Phone: ______________________________________ Fax: _______________________________________

Patient Signature: ____ Date: _____ / _____ / _________

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Electronic Record in **XML** to please including:

☐ Allergies & adverse reactions
☐ Health Assessment / ☐ Health Summary
☐ Investigation Reports
☐ Immunisation History
☐ GP Care Plan (721)
☐ Team Care Arrangement (723)
☐ Specialist Letters
☐ Visit Notes

☐ **All Existing Records**

I authorise for this release to be;

□ Securely Faxed / emailed to the requesting practice

□ Sent by mail to the requesting practice (If sending by CD, format must be in XML.)

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Office Use Only:

Date Request Received: _____ / _____ / __________ Date Records Sent: _____ / _____ / ________

Sent by: [ ] Mail [ ] Fax [ ] E-mail

Name of Person completing release: ____

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