THE DOCTORS.
HOPE ISLAND

2/331 Hope Island Road, Hope Island Qld 4212
Tel: 07 5651 4778 | Fax: 07 5621 0426 | E-mail: contact@thedrshopeisland.au
Postal: PO Box 522, Sanctuary Cove Qld 4212

REQUEST FOR MEDICAL RECORDS TRANSFER

The following parties have given directions that they wish to receive medical services from our Medical Practice as our patients. In accordance with their instructions and to facilitate the management of their healthcare please forward the following outlined documents by

Mail (postal address above) | **Fax** (Fax number above) | **Electronic** (Version format should be Medical Objects)

Medical Practice

Medical Practice Name____

Address____

Telephone_______________________ Facsimile_______________________

Patient Particúlars

Patient Full Name_______________________________DOB______________

Address____

Dependents or Other Family Members (Under the age of 18 years old)

1.Name_______________________________DOB______________

Address if not the same____

2.Name_______________________________DOB______________

Address if not the same____

Additional Dependents: **Y / N** (If Yes, particulars shall be outline and Annexed to this form on a 2nd Page)

Reqúested Records

ALL PATIENT HISTORY ☐ PROFESSIONAL & SPECIALIST REPORTS ☐

ACCURATE HEALTH SUMMARY WITH RELEVANT CORRESPONDENCE & RESULTS ☐

DETAILS OF ANY CDM OR PIP ITEMS CLAIMED WITHIN THE LAST 24 MONTHS (2YRS) (ie:GPMP/TCA) ☐

COPY OF HANDWRITTEN RECORDS FOR THE LAST 12 MONTHS (1YR) ☐

Patients Aúthoritý and Direction

I hereby give consent for my medical records to be released to:

Dr James (Se Hyun) Lee ☐ **Dr Dina Grigoreva** ☐ **Dr Noushin Majdteymouri** ☐ **Dr Mary-Anne Lee** ☐

SIGNED BY PATIENT_______________________________ **DATE / /**