Southern Cross Medical Centre
Suite 6, 36-40 Stuart Ave,
Hampton Park Vic 3976
Tel: 03 9799 2233 Fax: 9799 3006
ABN 34 101 383 659

Date………………..

Dear Doctor……………………………

Clinic name and address…………………………………………………

………………………………………………………………………………

Re………………………………………………………………………….

Date of Birth………………………

Old Address:………………………………………………………………

This patient is now attending this clinic and has requested that a copy of their medical records be transferred to our clinic. Please send either copies or a summary of their history. If sending by electronic format, please ensure that it is pdf,html, tif and/or doc files.

PLEASE DO NOT SEND THEIR ORIGINAL FILES.

In particular I would appreciate details about………………………………

………………………………………………………………………………

Please also provide the last dates for the following (if applicable): GPMP (721) __/ __/ ____ ,

TCA (723) __/ __/ ____ ,

Annual Health Assessment (703, 705, 707) __/ __/ ____ ,

Diabetes Cycle of Care __/ __/ ____,

Mental health Treatment Plan (2700, 2715, 2717, 2719) __/ __/ ____.

Thank you for your help,

Authorisation

I,………………………………………………, authorise the release of my/my family's medical records.

Please send them to Dr……………………………. at the above address.

Signed………………………….. Date………………………