Health 104
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HEALTH 104
personalised health & wellness centre

Transfer of Medical Records Form

Welcome to Health 104. We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

PATIENT INFORMATION

Title: Mr Mrs Ms Miss Other

First name: _____Preferred name:_____

Last name: _____ Date of birth: ____/____/_____

Street: _____

City/Suburb: _____ Postcode_____

Additional family members requesting transfer of history:

…… D.O.B. ……

…… D.O.B. ……

…… D.O.B. ……

TRANSFERRING FROM

Practice Name: _____

Dr: _____

Address: _____

Street: _____

City/Suburb: _____ Postcode_____

PATIENT AUTHORITY

I hereby give authority for a copy of my medical history and the medical history of any other listed family members, to be released to Health 104.

Patient Signature: _____ Date: _____

Full Name (PLEASE PRINT): _____