



Request for Records.

Date: _____

Dear Dr _____

Practice Name: _____

Practice Address: _____

Ph: _____

F: _____

E: _____

As the patient listed below now attends this practice, please forward a copy of their medical records and any other relevant clinical information to assist in the continued management of their healthcare.

Patient's Full Name: _____

Date of Birth: _____

Address: _____

Contact number: _____

Please advise if the patient has a GPCCMP or Mental Health Care Plan in place.

GPCCMP Date: _____ Review Date: _____

MHCP Date: _____ Review Date: _____

Electronic transfer in **.xml** format is preferred.

Patient consent:

I, _____ consent to the release of my medical records and any other relevant clinical information to Village Medicine Brunswick Heads.

Patient name: _____

Patient's Signature: _____ Date: _____

If not patient signing – name: _____

Your patient relationship (Eg: Mother, Father, guardian): _____

Warm regards,

Dr Catriona Quinn

Once you've completed the form, please return it to Village Medicine by email at hello@villagemedicine.com.au or fax on 02 5643 9278. Our team will take care of the process from there and keep everything as straightforward as possible. If you're unsure about any step, we're here to help.