eclipse MEDICAL

Transfer Medical Records Consent Form

I _____ (Name of Patient)

_____ (DOB of Patient)

Of, _____ (Address of Patient)

_____

_____ (Patient signature)

_____ (Date)

Authorise, _____ (Name of Previous Doctor)

_____ (Address of Previous Doctor)

_____ (Suburb and Postcode)

_____ (Phone Number)

_____ (Fax Number)

To release a copy of my health record to be forward to above Clinic

Dear Doctor,

This patient will now be attending this clinic under our care.
We would appreciate if you would forward a copy of his/her

☐ Full Medical History ☐ Health Summary

Yours sincerely

☐ Dr Glen Mulhall ☐ Dr Piotr Swierkowski

☐ Dr Suzette Pyke ☐ Dr Robert Francis

Eclipse Medical
303/3 Emporio Place, Maroochydore 4558
Ph. 07 5329 2105

Please forward via:
- **Medical Objects** to requesting Practitioner (preferred)
- Sent by mail to: 303 /3 Emporio Place, Maroochyore 4558