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

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

☐ Dr Glen Mulhall ☐ Dr Fiona McLellan

☐ Dr Suzette Pyke ☐ Dr Robert Francis

☐ Dr Vibeke Morrell ☐ Dr Carita Shield

☐ Dr Karen Baynon

Eclipse Medical
303/3 Emporio Place, Maroochydore QLD 4558
Ph. 07 5329 2105 Fax: 07 5560 0609

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