To Whom It May Concern

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Please arrange for the transfer of medical records as authorised below.

Patient:

First Name _____ Middle Name _____

Last Name _____

Home Address _____

_____ State _____ Postcode_____

Date of Birth ___ /___ /_____ Contact telephone number _____

Patient Authorisation:

I hereby authorise the following clinics and or hospitals:

1. _____

2._____

3. _____

4. _____

5. _____

to release copies of my medical records to:

Thrive Medical
37 O'Keefe Street (PO Box 841N)
Cairns North, QLD 4870
Ph: (07) 4019 2960
Fax: (07) 4214 5720

If the patient has had a GP Management Plan, Team Care Arrangement, Health Assessment or Mental Health Care Plan completed at your Practice could you please send the most recent of these documents. For all female patients, could their Pap Smear results also be included.

Note: We use Best Practice - please send full medical files on BP .xml format.
Or send electronically via: Medical Objects: Thrive Medical or Health Link: thrivemd

Signed

_____

Patient / Guardian Signature

Date ___/___/_____