Hamilton Family Practice

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Hamilton Vic. 3300
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Medical Records Request

*******We do not accept CD's other than BEST PRACTICE*******
Word and PDF also acceptable

I, _____
(Patient's Name)

Of, _____
(Patient's Address)

_____ State _____ Postcode _____

Date of Birth: / /

Consent to _____ (Previous Medical Clinic)

Address of Clinic _____

_____

Suburb _____ State _____ Postcode _____

Phone: ( )_____ Fax ( ) _____

Releasing my Medical Records to Hamilton Family Practice.

I acknowledge that these Medical Records may include Confidential Information and that there may be a cost involved with the transfer from my previous Doctor.

Patient's Signature: _____DATE.....20....

ADDITIONAL FAMILY MEMBERS (16 YEARS AND UNDER)

NAME	DATE OF BIRTH	SIGNATURE

LAST 721/723/732/2700/2715.....

Additional requests

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