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Request for Medical Records Transfer to another Clinic

To Doctor: _____

I hereby request that my medical records to be forwarded to:

Clinic details:		
Patient full name :	Patient address:	Date of birth :

I request the following information to be sent

Full Medical History	Health summary Only	Specific information. Please indicate.

Consent to send medical records:

Patients Name: _____

Signature: _____

Date: _____

*** Please note that requesting transfer of your medical records will relinquish all responsibility for recalls, reminders and follow up appointments. This will now be the responsibility of your new clinic. Please advise Reception if you wish to remain on our recall/reminder system***