LAKES BOULEVARD MEDICAL
HEALTH GROUP
547 The Lakes Boulevard, South Morang VIC 3752 | T: (03) 9436 0966 | F: (03) 9436 5900 | www.lakesboulevardmedical.com

Transfer of Medical Records Consent Form

I, _____Name of Patient

of, _____ Address of Patient

_____

_____ DOB

authorise, _____ Name of Practice

to release my patient health record/summary to:

Lakes Boulevard Medical

547 Lakes Boulevard, South Morang, VIC – 3752

Ph: (03) 9436 0966 Fax: (03) 9436 5900

_____ Patient signature

_____ Date

I authorise for this release to be:-

☐ **Faxed to the requesting practice or**

☐ **Sent by mail to the requesting practice**

[Please forward an electronic (XML) file of the records via CD]

Office Use Only:

Date Copy Sent: _____

Signature of Practice Representative: _____

☐ Entered copy of transfer request in the Medical Record