BALWYN CENTRAL MEDICAL
HEALTH GROUP
427 Whitehorse Road, Balwyn VIC 3103 | T: (03) 9830 2300 | F: (03) 9830 2355 | www.bcmedical.com.au

Transfer of Medical Records Consent Form

I, _____give consent for my medical records to be released to **Balwyn Central Medical.**

Patient D.O.B: _____ Address of Patient: _____

_____

Patient previous clinic/GP: _____

Phone: _____ Fax: _____

Parent signature: _____

Date: _____

Please include the following:

- ☐ Health Summary
- ☐ Health Assessment
- ☐ GP Care Plan (721)
- ☐ Team Care Arrangement (723)
- ☐ Investigation Reports
- ☐ Immunisation History
- ☐ Visit Notes
- ☐ Specialist Letters

I authorise for this release to be:-

□ **Faxed to the requesting practice or**

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

If sending by mail, CD must be in XML format.

_____

Office Use Only:

Date Copy Sent: _____

Signature of Practice Representative: _____