



Whitsunday  
Family Practice

Shop B6  
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## REQUEST FOR MEDICAL RECORDS TRANSFER

### Previous GP Practice/Health Facility

Practice \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Patient Authority

I (Name) \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Request that my health summary or full records along with the below dependents be forwarded to  
Whitsunday Family Practice.

Notes: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Dependents UNDER 18 ONLY:

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ M or F

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ M or F

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ M or F

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ M or F

#### OFFICE USE ONLY

Dear Doctor,  
The above mentioned is now attending this practice.  
Would you kindly forward their clinical records or an  
accurate health summary, with relevant  
correspondence, to assist in the future management  
of this patient. **Our practice uses Best Practice  
Software and preferably records are sent in  
XML format.**



Yours sincerely Doctor: \_\_\_\_\_

**PLEASE ENCLOSE THIS FORM WHEN RETURNING RECORDS.**