SPRINGWOOD
FAMILY MEDICAL

Shop10, 49-51 Cheek Ave
Gawler East SA 5118
Phone: 85231880

REQUEST FOR RECORDS FORM

Doctor: ____

Practice Name: ____

Address: ____

Suburb: ____

Phone: ______________________ Fax:______________________

Date: ____/____/____

Dear Doctor,

The Patient/s listed below are attending our Practice. We would be grateful if you could forward a copy of their:

- [ ] Full Medical Records
- [ ] Health Summaries
- [ ] Specialist Letters
- [ ] Care Plans
- [ ] Mental Health Plans
- [ ] Other:

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For ongoing care. If a fee is charged for the transfer of any patient information, please contact and advise the patient directly.

Files to be transferred

1. Patient's Name ____DOB _____/_____/______
2. Patient's Name ____DOB _____/_____/______
3. Patient's Name ____DOB _____/_____/______

Signatures of Patient

1.__________________________ 2. ________________________ 3.____________________

Signatures for Patients 16yrs & over

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