LOWNDES STREET CLINIC

2/9 Lowndes St, Kennington VIC 3550
Ph: 03 5443 5117 | Fax: 03 5443 5200
www.lowndesstreetclinic.com
admin@lowndesstreetclinic.com

MEDICAL HISTORY TRANSFER REQUEST

Dear Doctor: .....

At: .....

.....

(insert clinic postal address above)

The following patient/s is/are now attending this clinic. We ask that you please forward Medical Records as soon as possible.

Name: ..... D.O.B. .....

Name: ..... D.O.B. .....

Name: ..... D.O.B. .....

Name: ..... D.O.B. .....

Previous Patient Address:……..

Current Patient Address:……

PATIENT AUTHORITY

I/We give consent for the transfer of my/our file/full medical history (including MP, TCA, H/A , REPORTS, RESULTS & HMR) to be forwarded to Lowndes Street Clinic.

Patient Signature: ..... **Date:** .....

Patient Signature: ..... **Date:** .....

Patient Signature: ..... **Date:** .....

Patient Signature: ..... **Date:** .....

Thank You.
Yours Sincerely,
Dr Irini Missak
Dr Rasika Dona
Dr Rajini Kajarajan
Dr Gayani Edirisooriya

Any relevant billing information/ dates regarding the following Medicare Item Numbers/services would also be appreciated:

721, 723: 900/903: 2715, 2717

BEST PRACTICE COMPATIBLE USB/ DISC ONLY – PLEASE SEND IN XML FORMAT

The information contained in this document is legally privileged and confidential, intended only for the use of the individual named above. If the receiver is not the intended recipient the receiver is hereby notified that any use, dissemination, distribution, publication or copying of this facsimile is prohibited. If you have received this facsimile in error, please notify the practice immediately and arrangements will be made to retrieve or destroy it.