PO Box 4050 Elanora QLD 4221
Telephone: 07-55981300
Facsimile: 07-55982043
Email: administration@pinesfamilypractice.com.au

Date: ______________________________

Dear Dr: ____

Address: ____

Facsimile: ____

The following patients listed below are now attending The Pines Family Practice. They have requested that you please forward to us copies of their medical records.

	PATIENT NAME	DOB	PREVIOUS ADDRESS
1.	....	....	....
2.	....	....	....
3.	....	....	....
4.	....	....	....

PATIENT AUTHORITY

I ____hereby authorise the above request for the transfer of my medical records to The Pines Family Practice.

Patient Signature: __________________________________ **Date:** _______________

Thank you for your assistance in this matter: **Dr.**
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PLEASE TRANSFER USING <u>MEDICAL OBJECTS</u> IF POSSIBLE