MAIN STREET MEDICAL CENTRE MERIMBULA

6/93 MAIN ST, MERIMBULA NSW 2548

PHONE: (02) 6495 2555 FAX: (02) 6495 2021

PATIENT REQUEST FOR MEDICAL RECORDS

Date of request _____/_____/_____ Name of previous doctor________________________________

Address of previous doctor ____

Phone no. of previous doctor __________________Fax no. of previous doctor________________

Dear Doctor,

Re: Patient Name ____

Patient Address ____

Patient DOB___________________________

Patient phone number____________________________________Mobile__________________

The above patient is now attending our practice and has requested that you forward their medical records to us and also release any CDM net information. If you are using that Medical Director software, we would appreciate the notes being sent on a disc in XML format. Otherwise if you would be kind enough to send only a brief summary including any recent or relevant letters. Please note if sending a complete file or over 10 pages- please no paper, disk only.

Please also fill out the below history for this patient in the table provided.

PLAN ITEM	IF COMPLETED PLEASE NOTE ITEM NUMBER AND DATE WHEN LAST CLAIMED
1. GPMP (ITEM 721)	
2 TCA (ITEM 723)	
3. GPMP OR TCA REVIEW (ITEM 732)	
4. MENTAL HEALTH (ITEMS 2700-2717)	
5. HEALTH ASSESSMENT (ITEMS 701,703, 705)	
6. ASTHMA CYCLE OF CARE (ITEMS 2546,2552,2558)	
7. DIABETIES CYCLE OF CARE (ITEMS 2517,2521,2525)	
8. ANY RECENT PAP SMEARS	

Patient Authority

I, (print patient name) ____ hereby authorise the transfer of my confidential health records to Main Street Medical Centre, Merimbula NSW.

Signed ________________________________Date ____________________

Regards, Main Street Medical Centre- Merimbula