Moffat Beach Family Medical Practice

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REQUEST FOR TRANSFER OF MEDICAL RECORDS

Patient Information

Surname: _____ **Given Name:** _____

DOB: _____ **Ph:** _____

Address: _____

Release Medical Records From:

Practice Name: _____

Practice Address:_____

Phone: _____ **Fax:** _____

Requesting: *[state specific information]* _____

Doctor's Name: _____

Please note if the following have been carried out: SURGERY TO COMPLETE

GPMP & TCA (721 / 723)	Date:	_____
Mental Health Care Plan (2715/2717)	Date:	_____
Any type of Health Assessment	Date:	_____

I _____ (print name) hereby consent to the release of my clinical information/medical record(s) from the above-named medical provider to the Moffat Beach Family Medical Practice. I am now seeing Dr _____.

Patient's signature: _____ Date: _____

Thank you for your prompt attention. Our preferred method of receiving medical record is in a XML format.