ADELAIDE HEALTH CARE

43 Carrington Street
ADELAIDE SA 5000
PH: (08) 8410 0774
FAX: (08) 8410 0779

Dr Michael Notley
017605BW

Dr Moira McCaul
015444GL

Dr Jenny Gunn
026794EK

Dr Jemma Elliott
262472JK

Dr Kate Le Cong
262281LA

Dr Julia Chan
2473738K

Dr Kirsty Anderson
2416946J

Dr Meredith Frearson
000834YF

Dr Tiana Della-Putta
030127AW

Dr Annabelle Hocking
297813TT

Dr Helen Mullner
2317037T

Dr Keith Brewerton
030266CT

Dr Robyn Seto
409360JH

Dr Chiaw 'Malcolm' Lee
297878VA

Dr Carmel Reynolds
247011KX

Dr Phuc-Tam 'Andrew' Trang
5658852H

Dr Taisa Dorniak-Wall
461807VL

Dr Wendy Wen
5097497B

REQUEST FOR TRANSFER OF NOTES

DATE: _____

DEAR DOCTOR: _____

OF (*CLINIC NAME IF KNOWN*): _____

_____

PHONE NO.: _____

FAX NO.: _____

The following patient is now attending this practice for their ongoing medical care:

NAME: _____

DOB: _____

ADDRESS: _____

_____

It would be appreciated if you would forward :

A complete copy of their medical records (if you have Best Practice or Medical Director, please provide notes on CD in XML format).
And / or the following:

- ☐ Health summary
- ☐ All specialist letters
- ☐ Pathology results
- ☐ Other _____
- ☐ X-ray results
- ☐ Any other relevant information

Please advise on most recently billed dates for the following:
Yours sincerely,

- ☐ 701 Date:_____
- ☐ 703 Date:_____
- ☐ 705 Date:_____
- ☐ 707 Date:_____
- ☐ 721,723 Date:_____
- ☐ 900 Date:_____
- ☐ 2712 Date:_____
- ☐ 2715 Date:_____

Dr _____

I hereby give consent for the release of my medical information, as specified, to the above named doctor.

PATIENT SIGNATURE: _____

DATE: _____