

**ADELAIDE
HEALTH
CARE**

**43 Carrington Street
ADELAIDE SA 5000
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**Dr Michael Notley
017605BW**

**Dr Moira McCaul
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**Dr Jenny Gunn
026794EK**

**Dr Maureen Gallagher
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**Dr Kate Le Cong
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**Dr Julia Chan
2473738K**

**Dr Kirsty Anderson
2416946J**

**Dr Meredith Frearson
000834YF**

**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 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: _____

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

PATIENT SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

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).

Including the following:

- | | |
|---|---|
| <input type="checkbox"/> Health summary | <input type="checkbox"/> X-ray results |
| <input type="checkbox"/> All specialist letters | <input type="checkbox"/> Any other relevant information |
| <input type="checkbox"/> Pathology results | |
| <input type="checkbox"/> Other _____ | |

On return of records, please advise on most recently billed dates for the following:

- | | |
|--|--|
| <input type="checkbox"/> 701 Date: _____ | <input type="checkbox"/> 721,723 Date: _____ |
| <input type="checkbox"/> 703 Date: _____ | <input type="checkbox"/> 900 Date: _____ |
| <input type="checkbox"/> 705 Date: _____ | <input type="checkbox"/> 2712 Date: _____ |
| <input type="checkbox"/> 707 Date: _____ | <input type="checkbox"/> 2715 Date: _____ |