Open Monday to Friday 9am – 5pm

Phone: 03 9803 1022
Fax: 03 9803 6041
880 High Street Road

Glen Waverley VIC 3150

Kerrie Road
FAMILY MEDICAL CENTRE

Medical History Transfer Request

I request that my medical history including all relevant results and correspondence be transferred from:

Name of Practice: ____

Practice Address: ____

____

Telephone Number: ____

Fax Number: ____

To the new practice I have chosen:

Name of Practice: Kerrie Road Family Medical Centre

Address of Practice: 880 High Street Road

Glen Waverley VIC 3150

Telephone Number: 03 9803 1022

Fax Number: 03 9803 6041

Patients Name: ____

Date of Birth: ____

Address: ____

____

Patient Authorisation:

I authorise Kerrie Road Family Medical Centre to receive my full medical history.

Signed: ______________________________Date: ______________________

This form is intended only for the practice it has been addressed to. If you receive this form in error please notify the sender immediately and destroy this document securely.