CANTERBURY CLINIC

Authority For Transfer Of Medical Records

Dear Doctor: _____

Name of Clinic: _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Phone: _____ **Fax:** _____

Reason For Transfer: _____

Thank you for the transfer of medical records relating to:

I (Patient's full name) _____

Date of Birth: ____/____/____

Of (Patient's current address) _____

_____

Authorise to release of my medical records to be forwarded to Canterbury Clinic.

Signed: _____ **Date:** ____/____/____

Also for family members listed below:

Name: _____ **Date of Birth:** ____/____/____ **Signed:** _____

Name: _____ **Date of Birth:** ____/____/____ **Signed:** _____

Name: _____ **Date of Birth:** ____/____/____ **Signed:** _____

Please include dates of:

- ☐ **Care Plan:** ____/____/____
- ☐ **Team Care Arrangement:** ____/____/____
- ☐ **Mental Health Care Plan:** ____/____/____
- ☐ **Health Assessment:** ____/____/____
- ☐ **Diabetes Cycle of Care:** ____/____/____
- ☐ **Asthma Cycle of Care:** ____/____/____

Please transfer these records to:

Canterbury Clinic

508 Canterbury Road, Vermont, Vic 3133, Phone: 03 9873 0809, Fax: 03 9873 1477
admin@canterburyclinic.com.au

E: