



TRANSFER OF RECORDS FORM

PREVIOUS PRACTICE

Dear Dr:

Address:

Email: Phone:

PATIENT CONSENT

I

Herby consent to release my full medical records to:

West Kentish General Practice
628 West Kentish Road
West Kentish TAS 7306
Phone: 0437 034 714
Email: admin@westkentishgp.com

PATIENT DETAILS

Name:

DOB:

Address:

Previous Address:

Signature of patient or guardian: **Date:**

** We prefer an electronic copy of the records in XML format.

**Postal Address: 286 Old Paradise Road, Sheffield TAS 7306