Date:…….

Attention Dr: ……..

Practice Address: ……..

……..

The following patient(s) are now attending our practice. It would be appreciated if you could transfer a copy of their medical records to our practice for continuation of their medical care. If possible could you please advise the dates that any of the following have been billed:

721 Date……...

723 Date……...

732 Date……...

Mental Health Date……...

(2700/2701/2715,2770,2712,2713)

Our preference is to receive Medical records in **electronic format** and our system requires the files to be in **PDF format only** – thank you for your assistance in this matter.

Name……. DOB……

Name……. DOB……

Name……. DOB……

Name……. DOB……

Previous Address:……

…….

Current Address:……

……

I consent to the transfer of my/our records to Myall Medical Practice.

Signature:……. Date……

Requesting Doctor ……

myallmedical PRACTICE

Dr Kevin Lynch
Dr Ross Maxwell
Dr John Bechtel
Dr Marianne Gall
Dr Felipe Londono
Dr Kate Hart
Dr Tammy Maxwell
Dr Deepama Sumanasekera
Dr Mindy Crowe
Dr Sally Wu
Dr Talisha Condon
Dr Lotte Verhoef

Myall Medical Practice
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