



PO Box 4050 Elanora QLD 4221
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Date: _____

Dear Dr: _____

Address: _____

Facsimile: _____

The following patients listed below are now attending The Pines Family Practice. They have requested that you please forward to us copies of their medical records.

	PATIENT NAME	DOB	PREVIOUS ADDRESS
1.
2.
3.
4.

PATIENT AUTHORITY

I _____ hereby authorise the above request for the transfer of my medical records to The Pines Family Practice.

Patient Signature: _____ **Date:** _____

Thank you for your assistance in this matter: **Dr.** _____

We would appreciate digital records please. XML format from Medical Director, HTML format from Best Practice or via Medical Objects to the above Doctor.