# Transfer of Medical Records Consent Form

The following template forms the basis of a suggested Transfer of Medical Records Consent Form. You may wish to copy / re-type the information on to your own Practice letterhead or simply use the form as a guide to develop your own Consent Form.

I, ________________________________________________Name of Patient

of, ________________________________________________Address of Patient

__________________________________________________

__________________________________________________ DOB

authorise, __________________________________________Name of Practice

to release my patient health record/summary to

__________________________________________________ Name of Doctor/Practice

__________________________________________________ Address of Practice

__________________________________________________ Patient signature

__________________________________________________ Date

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Office Use Only:

Copy Sent: ____________________

Signature of Practice Representative: ___________________________

☐ Entered note of transfer in the Medical Record

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Note: GPA ACCREDITATION plus has provided this document as a guide only – your Practice may add or delete items as relevant to your Practice.