



# Burton Street Family Practice

23 BURTON Street  
BENTLEY WA 6102  
WWW.BURTONST.COM.AU

TELEPHONE: 9458 4558  
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E: reception@burtonst.com.au

## Request to transfer medical records

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We wish to advise that the patient(s) listed below are now attending our practice. To ensure continuity of care, could you please forward their medical records in order to assist in our management of this patient(s).

We understand that a fee may apply and request that the patient be advised of any fees relating to the copy and transfer of their medical records.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Post Code: \_\_\_\_\_

I hereby give consent for the transfer of medical records to Burton Street Family Practice.

Signature: \_\_\_\_\_

Patients over 16 years of age **MUST** sign to authorise transfer of their medical records

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature: \_\_\_\_\_

Please note our practice uses Medical Director software. If you use Medical Director or Best Practice, please send the XML file. If you use other software, please send in PDF format.

Records can be forwarded on a disc by mail or email (reception@burtonst.com.au).

Our practice does **NOT** accept paper records.

Yours sincerely,

\_\_\_\_\_  
Dr \_\_\_\_\_