Unit 1, Beeliar Hive Shopping Centre
283 Beeliar Drive, Yangebup WA 6164
Phone: 08 6117 0480 **Fax:** 08 6117 0481

LAGOON MEDICAL CENTRE

Dr George Andrawis **Dr Mohamed Abou El-Alamein** **Dr Gagandeep Kundal**
Dr Anwar Jawad **Dr Francis Akinyemi** **Dr Charles Meribole**

TRANSFER OF MEDICAL RECORDS CONSENT FORM

TO:
_____

_____

Dear Doctor,

We wish to advise you that the following patient(s) are now attending our surgery, and to ensure the continuity of care, it is requested that their medical records are transferred to Lagoon Medical Centre.

***We accept medical records by fax, post, or CD disc. We use Best Practice software, so XML format is preferred. We understand that there may be fees involved in requesting medical records, could you kindly inform the patient of the fees if required.*

I hereby authorise the release of my/our medical records to Lagoon Medical Centre.

Patients name: _____ D.O.B. _____

Address: _____

_____

Patient's Signature: _____ Date: _____

Please include other members of my family as listed below: ***Patients 18 and above please sign***

Family Member: _____ D.O.B. _____

Signature: _____

Family Member 2: _____ D.O.B. _____

Signature: _____

Family Member 3: _____ D.O.B. _____

Signature: _____

**We would also appreciate the EPC history of the patient(s) listed below.*

GPMP (Item 721)		
TCA (Item 723)		
GPMP/TCA Review (Item 732)		
Health Assessment (Item 701, 703, 705 & 707)		
Mental Health Care Plan (Item 2715 / 2717)		

Records to be forwarded to: Dr _____