**Dr Raymond J Mullins**

Suite 1, John James Medical Centre, 175 Strickland Crescent, Deakin ACT 2600

Tel 02-6282 2689; fax 02-6282 2526

**REQUEST FOR TRANSFER OF MEDICAL RECORDS**

**Receiving practice name**

Tel:

Fax:

Email (if available)

**PATIENT DETAILS**

Name (or previous name)

Date of birth

Address

Email

Patient Signature

**OTHER FAMILY MEMBER MEDICAL RECORD TRANSFER REQUESTS**

Name Date of birth

Name Date of birth

Name Date of birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is now attending this practice and has requested that a copy/summary of their medical records be forwarded to the above address.

Date of request \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_