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Patient File Transfer Request

Patient Name:

Date of Birth:

Address:

Parent/guardian name if patient is a minor:

I request that copies of reports held on file by Dr Paul Campbell be forwarded to the following doctor:

Name of new doctor:

Practice:

I the undersigned, declare that I am legally entitled to request the transfer of the patient record.

Signature of patient:

OR: If you are requesting this information as the parent or legal guardian of the above patient please sign here:

Relationship to patient:

Date:

Please be aware that this form must be fully completed before we are able to action your request.

OFFICE USE ONLY:
File sent via:

- Fax
- Email
- Medical objects
- Post

Date: