St James Family Medical
St James Specialist

**TRANSFER OF MEDICAL RECORDS**
**REQUEST & CONSENT**

Dear: Dr _____

Clinic: _____

Ph: _____

Fax or Email: _____

Dear Dr _____,

The patient listed below wishes to transfer their medical records to St James Family Medical & St James Specialist and is requesting that his/ her complete health records are sent to our clinic to assist with their ongoing care.

Please forward at your earliest convenience to info@stjamesfamilymedical.com.au or via Health Link to *stjamesf*

**Patient Consent:**

I give my permission for my complete health records to be transferred to St James Family Medical & St James Specialist as I will be attending this clinic for ongoing medical care.

Patient Name: Kasey Robert Jones

Date of Birth: 16/12/2013

Address: 40 Toledo circuit port kennedy

Patient/ Guardian Signature: _____