Reynolds Rd 7 Day
MEDICAL CENTRE

Level 1 / 39 Reynolds Road
Mount Pleasant, WA 6153
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Dear Doctor

Re: Request for transfer of patient medical records

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient (full name): _____

Address: _____

Date of Birth: _____

Patient consent

I, _____ consent to the release of my medical records and any other relevant clinical information to Reynolds Road 7 Day Medical Centre

Patient name: (please print) _____

Signature: _____ Date: _____

Yours sincerely

Reynolds Road 7 Day Medical Centre