**Dr Raymond J Mullins**

PO Box 4206, Kingston ACT 2604

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_