myCHECK HEALTH
MEDICAL & SKIN

PATIENT REQUEST FOR MEDICAL RECORDS

Date of request _____/_____/_____

Name of previous doctor: _____

Name of previous practice: _____

Phone no. of previous doctor _____ Fax no. of previous doctor_____

Dear Doctor,

Re: Patient Name _____

Patient Address _____

Patient DOB _____

Patient phone number _____Mobile_____

The above patient is now attending our practice and has requested that you forward their medical records to us and also release any CDM net information. If you are using that Best Practice software, we would appreciate the notes being sent on a disc/ memory flash in XML format. Otherwise if you would be kind enough to send only a brief summary including any recent or relevant letters. Please note if sending a complete file or over 10 pages please no paper, disk only.

Please also fill out the below history for this patient in the table provided.

PLAN ITEM	IF COMPLETED PLEASE NOTE ITEM NUMBER AND DATE WHEN LAST CLAIMED
1. GPMP (721)	
2 TCA (723)	
3. GPMP OR TCA REVIEW (732)	
4. MENTAL HEALTH (2700-2717)	
5. HEALTH ASSESSMENT (701,703, 705, 707)	
6. ASTHMA CYCLE OF CARE (2546,2552,2558)	
7. DIABETES CYCLE OF CARE (2517,2521,2525)	
8. RECENT CERVICAL SCREENING	
9. Other	

Patient Authority

I, _____ hereby authorize the transfer of my confidential health records to myCheck Health Clinic, Woy Woy NSW 2256

Signed _____Date _____

Regards, myCheck Health Clinic, Woy Woy NSW 2256