## TRANSFER OF MEDICAL INFORMATION

## Please return to reception@southerncentralcardiology.com

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| **STEP 1: YOUR NAME**  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient's Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(address), request and consent to the transfer of medical correspondence/results relating to my medical treatment.held by Southern Central Cardiology to :

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| **STEP 2: YOUR NEW GP OR CARDIOLOGIST** |

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **STEP 3: Are photocopies required or do documents need to be faxed? (Leave blank if not required)** |

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| **P**ostal address: |  |

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| **Fax Number:** |

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| **NOTES** |

**An administration fee of up to $200 may be charged for transfer of larger files, files that require photocopying/postage/transmission by fax. This will need to be prepaid. This will be assessed once we receive this form. We do not forward copies of letters sent to us by others without their consent.**

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| **STEP4: SIGNATURE** |

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| PATIENT SIGNATURE: | DATE: |