Doctor Aged Care

A.B.N 93433952780

Transfer of Medical Records Consent Form

PATIENT'S DETAILS

Patient's name: _____

DOB: _____

Address: _____

_____

The above named patient or their legal guardian consent to the release of health information regarding previous care at the practice detailed below to the doctors and health care staff of Doctor Aged Care. I understand this is necessary for my ongoing treatment.

Authorise to

Doctor Aged Care
Waters Edge, Level 1
2-8 Lake Street
Caroline Springs, VIC 3023
Tel: 1300 317 071
Fax: (03) 8610 1011
Email: admin@doctoragedcare.com.au

Patient or legal guardian's signature: _____ Date: _____

PREVIOUS DOCTOR DETAILS

Dr Name / Clinic: _____

Address: _____

Phone no: _____ Fax No: _____

Please send the medical records to

Doctor Aged Care, Waters Edge, Level 1
2-8 Lake Street, Caroline Springs, VIC 3023
Tel: 1300 317 071 **Fax: (03) 8610 1011**

We prefer that you fax the health summary and documents or alternatively email documents in **PDF format** to admin@doctoragedcare.com.au

Please DO NOT send a CD

Doctors of Doctor Aged Care and associated centres comply with the privacy ACT (1998) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information.