MEDICAL SUPER CLINIC

Transfer of Medical Records Consent Form

Patient Name _____ **D.O.B.** _____/_____/_____

Signature _____ **Date** _____/_____/_____

Additional Family Members
(You may sign for your child/patient under your legal guardianship if they are minor/s).

Patient Name _____ D.O.B. _____/_____/_____

Signature _____

Patient Name _____ D.O.B. _____/_____/_____

Signature _____

Patient Name _____ D.O.B. _____/_____/_____

Signature _____

I hereby grant my consent for all medical records relating to me (and/or my child) to kindly be forwarded

FROM _____
(Practice holding your records)

TO _____
(General Practitioner)

at the MEDICAL SUPER CLINIC via fax, email, or Medical Objects.
Thank you.

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