Ontario Family Practice
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Website: www.ontariofamilypractice.com.au

Transfer of Medical Records

To Doctor: _____

Address: _____

Phone No/Fax No: _____

Re Patients: _____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

I HEREBY REQUEST AND AUTHORISE THE RELEASE OF MY MEDICAL RECORDS TO:
Ontario Family Practice

Signed: _____

Dated: _____

Our Practice uses Best Practice software. If your practice is also using this software we welcome you to transfer files electronically via CD as an XML.