KILMORE VILLAGE MEDICAL

I, _____give consent for my medical records to be released to Kilmore Village Medical.

Shop 7, 109 Northern Hwy, Kilmore VIC 3764.

Patient Date of Birth: _____

Patient Address: _____

Patient's previous clinic/GP: _____

Clinic Phone: _____

Clinic Fax: _____

Patient Signature: _____

Date: _____

Please include the following:

- ☐ Health Summary
- ☐ Health Assessment
- ☐ GP Care Plan (721)
- ☐ Team Care Arrangement (723)
- ☐ Investigation Reports
- ☐ Immunisation History
- ☐ Visit Notes Specialist
- ☐ Letters
- ☐ All Existing Records

I authorise for this release to be:

- ☐ Faxed to the requested practice
- ☐ Sent by mail or email to the requesting practice

If sending by email or mail, format to please be in XML

Kilmore Village Medical
Email: reception@kvmedical.au
Phone: 03 4714 8400
Fax: 03 4714 8407

OFFICE USE ONLY

Date copy sent: _____

Signature of Practice Representative: _____

TRANSFER OF MEDICAL RECORDS FORM