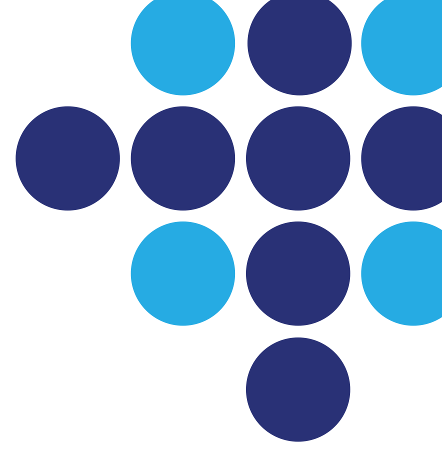
CHELSEA ARCADE MEDICAL



I, ____ give consent for my medical records to be released to Chelsea Arcade Medical, Shop 10 & 11, 426 Nepean, Hwy, Chelsea VIC 3196

Patient Date Of Birth:

____

Patient Address:

____

Patient's previous clinic/GP:

____

Phone: ________________________________

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 to the requesting practice

If sending by CD, format must be in XML

____

TRANSFER OF MEDICAL RECORDS FORM

OFFICE USE ONLY

Date copy sent: ____________________________

Signature of Practice Representative: ________________

ICO HEALTH GROUP

Shop 10 & 11, 426 Nepean Hwy,
Chelsea VIC 3196

P: (+61) 3 9772 9878
F: (+61) 3 9772 0897
icohealth.com.au