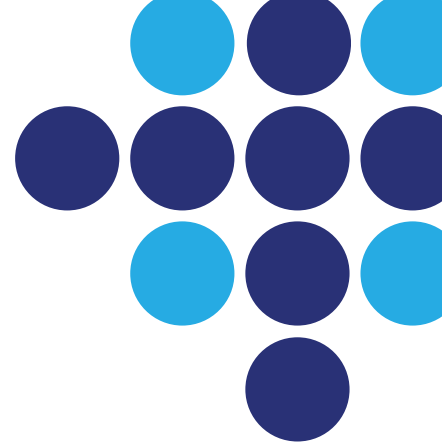


CHELSEA ARCADE MEDICAL



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:

- | | |
|--|---|
| <input type="checkbox"/> Health Summary | <input type="checkbox"/> Immunisation History |
| <input type="checkbox"/> Health Assessment | <input type="checkbox"/> Visit Notes |
| <input type="checkbox"/> GP Care Plan (721) | <input type="checkbox"/> Specialist Letters |
| <input type="checkbox"/> Team Care Arrangement (723) | <input type="checkbox"/> All Existing Records |
| <input type="checkbox"/> Investigation Reports | |

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: _____