BLUFF POINT
MEDICAL CENTRE

Medical Records Transfer Request Form

(Please forward the below completed form to reception@bluffpointmedical.com.au)

Dear Doctor / Practice: _____

Address: _____

Fax/Email: _____

The patient/s mentioned below would like to request that their full medical history be electronically exported and sent to;

Bluff Point Medical Centre
PO Box 3333
Bluff Point WA 6530
Reception@bluffpointmedical.com.au

Patient Name	DOB	Signature

By signing this form, I _____authorise you to release confidential health information about me to the doctor / practice mentioned below, who is now responsible for my ongoing care.

Signature:

Date:

Bluff Point Medical uses Best Practice software. We prefer secure transfers in XML format by email, disk or USB if exported from Best Practice/ Medical Director. Alternatively, we can accept PDF records if exported from another software.

If you have any troubles with this type or transfer, please contact us.