MEDIKA HEALTH CLINIC
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REQUEST FOR MEDICAL RECORDS

Previous Medical Centre: _____

Phone: _____ Fax: _____

I am requesting a copy of my full Medical Record to be transferred to this practice. Should there be a cost involved in this transfer I understand that I am liable for this.

Patient Name	**DOB**	**Signature**

The above mentioned patient/s are now attending this practice. Would you kindly forward their clinical file or an accurate health summary, with relevant correspondence and results, to assist in future management and continuity of care.

As we use Best Practice we ask that you please use .XML format and send via email or disk. If you do not use Best Practice please contact us for an alternative method.

Thank you,
Medika Health

Patient Signature: _____ Date: _____