Date:

Dear Patient,

Please complete this form and return to Lavington Clinic to help transfer your care to another Medical Clinic and /or receive a copy of your medical record.

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Name	DOB	Address
……	…../…../…..	……
Additional Family Members:		Signature (*if > 14yrs of age*):
.....	...../...../.....	.....
.....	...../...../.....	.....
.....	...../...../.....	.....
.....	...../...../.....	.....

The above-named Patient/s consent to release the medical records to the Medical Clinic / General Practitioner below. Individual consent/signing will be needed by people over 14 years of age.

Please forward either:

- A ***complete medical*** record on CD.
- A ***health summary*** which includes recent investigations and relevant correspondence.

A CD will be at a cost of $22 + GST. Please contact the clinic for payment.

PATIENT AUTHORITY

☐ I authorise Lavington Clinic to forward my/our medical records to Dr/ Medical Clinic

……

☐ I would like to arrange a copy for myself for when I find a new Dr/ Medical Clinic

Patient Signature……..... Date: ……..…….

Yours Faithfully,

Administration
Lavington Clinic