Victoria Clinic

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign own form

In order to receive the best care possible, I agree to Victoria Clinic obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: _____--

(Name of previous Medical Centre or Doctor)

Address:

Please transfer the medical records for the following people to Victoria Clinic

NHI	Family Name	Given Names	Date of Birth

Signed: _____--Date: _____

Second Request (If required) _____-Date: _____

Dr Grant Le Roux 41561
Dr Casey Van Vliet 47039
Dr Danny Liao 61884
Dr Katie Fourie 62088

Address Details
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GP2GP EDI: vicnthhm