**Request to Transfer Records**

Please use this form when requesting for your **medical (GP) or dental** record to be transferred to LCHS or Link



|  |
| --- |
| **Previous Clinic Name:** |
| **Address:** |
| **State: Phone: Fax:** |
| **Email:** |

*All fields must be completed for form to be processed*

The following patient and/or their dependents are now attending the Latrobe Community Health Service GP or Dental clinic.

They hereby give permission for you to release their records (as indicated below) to Latrobe Community Health Service.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name**: |  | **DOB:** | / / |
| **Phone:** |  |  |  |

**Other family members (if under 16yrs) – A separate form is required for anyone 16yrs or over**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  |  | DOB: | / / | | |
|  |  |  |  |  |  |  |
| Full Name: |  |  | DOB: | / / | | |
|  |  |  |  |  |  |  |
| Full Name: |  |  | DOB: | / / | | |

**Please tick all applicable record types:**

|  |  |
| --- | --- |
| **General Practice (GP):** | **Dental:** |
| Immunisation history | Complete record |
| Complete medical/clinical history including correspondence | Dental imaging only |
| Accurate health summary with recent correspondence/results |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature:** |  | **Date:** | / / |
| **Print name:** |  |  |  |

**Please forward records to us in .xml (Best Practice) or PDF format via email**

|  |  |  |
| --- | --- | --- |
| 🖳 **Email to:**  records@lchs.com.au | 🖂 Mail to:  Records Management  PO Box 960 Morwell Vic 3840 | ✆ Phone:  1800 242 696  Ask for Records Management Office |