



CANTERBURY
CLINIC

Authority For Transfer Of Medical Records

Dear Doctor: _____

Name of Clinic: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone: _____ Fax: _____

Reason For Transfer: _____

Thank you for the transfer of medical records relating to:

I (Patient's full name) _____

Date of Birth: ____/____/____

Of (Patient's current address) _____

Authorise to release of my medical records to be forwarded to Canterbury Clinic.

Signed: _____ Date: ____/____/____

Also for family members listed below:

Name: _____ Date of Birth: ____/____/____ Signed: _____

Name: _____ Date of Birth: ____/____/____ Signed: _____

Name: _____ Date of Birth: ____/____/____ Signed: _____

Please include dates of:

☐ Care Plan: ____/____/____

☐ Team Care Arrangement: ____/____/____

☐ Mental Health Care Plan: ____/____/____

☐ Health Assessment: ____/____/____

☐ Diabetes Cycle of Care: ____/____/____

☐ Asthma Cycle of Care: ____/____/____

Please transfer these records to:

Canterbury Clinic

389 Canterbury Road, Forest Hill, Vic 3131, Phone: 03 9873 0809, Fax: 03 9873 1477