

 Doctor:

 At:

 Phone:

 Fax:

Dear Doctor,

The following patient(s) are now attending our practice under the care of

Dr. . We would greatly appreciate if you could please forward a copy of their medical record to our practice as soon as possible.

Patient Name: DOB:

Patient Name: DOB:

Patient Name: DOB:

Patient Name: DOB:

Patient Authority

I, of (address) hereby give consent for my records to be transferred to

Dr. at the above address.

Signed: Date: