# Vitality Healthcare Medical Centre

55-56/ 81 Carrington Street, Adelaide, SA 5000
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info@vhcmedical.com.au

**To:** ______________________________

**Address:** ______________________________

**Tel:** ______________________________

**Fax:** ______________________________

The following patient/s have attended our medical centre recently and have requested to have his/her/their **HEALTH SUMMARY / COMPLETE MEDICAL RECORD** *(Please circle)* transferred to us.

*We accept any formats that is applicable to Best Practice Software e.g. XML or PDF.*

If applicable copies of their management care plan you have completed, please fill in the following tables and forward the copies to us to optimise their continuity of care.

| MBS Item Number | Date Billed |
|---:|---|
| 721 | |
| 723 | |
| 732 | |
| 2715 | |
| 2712 | |
| 703/705/707 | |

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Patient Authorisation:

I hereby authorise Dr ______________________________ to obtain a copy of my medical record.

**Patient Name:** ____________________ **D.O.B:** ____________________

**Address:** ______________________________

**Signature:** ____________________ **Date:** ____________________

Please include other members of my family (≤18 years-old) as listed:

Name: DOB:

Name: DOB:

Name: DOB:

Name: DOB: