

Maxwell Medical Group

Central West Shopping Centre

T22, 65-67 Ashley Street

Braybrook, Vic 3019

T: 7036 2450

F: 7036 2451

[info@maxwellmedical.com.au](mailto:info@maxwellmedical.com.au)

[www.maxwellmedical.com.au](http://www.maxwellmedical.com.au)

**Transfer of Medical Information Form (under 16years old)**

Thank you for taking the time to complete this form. It really helps us to have your medical records if you choose us as your regular GP. If you would like any help completing this form please speak to a member of our practice team.

**Personal Details**

Title:\_\_\_\_\_\_\_\_\_\_Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_

**Details of who currently holds your medical records**

Previous GP Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the parent/legal guardian of the person above give consent for their medical records to be released to Maxwell Medical Group, Central West Shopping Centre, T22, 65-67 Ashley Street, Braybrook, Vic 3019.

I authorise this to be sent by Fax Mail In electronic format

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office use only

\*\*We use Best Practice and would prefer if you could please send via BP .xml format, via CD or USB if possible\*\*

Dear Colleague, thank you for taking the time to arrange transfer of records.

Kind Regards

Maxwell Medical Group

Date Sent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_