

Authority to Transfer Medical Records

Patient Details

Full Name:

Date of Birth: / /

Address:

Mobile:

Email:

Medicare Number:

Previous Practice Details

Practice Name:

Previous GP (if known):

Practice Email:

Authority to Transfer Medical Records

I authorise the healthcare provider/practice named above to release and transfer my **complete medical record** to **Calen Health** for the purpose of continuity of care.

Please provide the patient's **entire medical record**, including where applicable:

- Complete health summary
- All progress/consultation notes
- Current and previous medications
- Care plans and reviews including Mental Health / Health Assessments
- Allergies and Immunisation History
- Pathology and investigation results
- Radiology and imaging reports
- Specialist letters and other clinical correspondence
- Recall and reminder information
- Any outstanding or pending results, referrals or follow-up requirements

Additional Clinical Information

Date of last Cervical Screening Test:

Date of last billed GP Mental Health Care Plan:

Date of last billed Chronic Disease Management Plan:

Date of last billed Health Assessment:



Additional Comments

Please include any additional information that may assist Calen Health with the patient's ongoing care and continuity of care, including any outstanding investigations referrals, recalls or recommended follow-up.

Patient Consent

I consent to the release and transfer of my complete medical record to **Calen Health**.

I understand that my previous healthcare provider may charge an administrative fee for the preparation and transfer of my medical records.

Patient Name:

Patient Signature:

Date: / /

Please Forward Records To:

Calen Health, PO Box 1113, Nedlands 6909

Email: admin@calenhealth.com.au

HealthLink EDI: calenhea

