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Request for Medical History Transfer

Attention

Previous Doctor _____

Clinic _____

Phone Number _____

Fax Number _____

Regarding

Patient _____

Date of Birth _____

Mobile Phone _____

Patient Information Required

- Complete Medical History
- Summary of their current Medical History

Please send the relevant medical information in XML or PDF format compatible to Best Practice.

Yours sincerely,

Doctor _____

Date _____

Patient Authorisation _____

(signature)