Northern Cardiology and Specialists' Clinic

Playford Health Hub
46 John Rice Avenue
Elizabeth Vale SA 5112

Clinic 08 8250 9050
Fax 08 8281 2511
Email cardiology@ncsc.com.au

TRANSFER OF MEDICAL RECORDS CONSENT FORM

I, give consent for my Medical Records to be released

to Northern Cardiology and Specialists' Clinic.

Patient Date of Birth:

Address:

Suburb: Postcode:

Patient Signature Date:

Patient Previous Clinic:

Phone: Fax:

Please include the following:

- ☐ All existing records
- ☐ Specialist letters
- ☐ Investigation reports
- ☐ Visit notes

I authorise for this release to be;

- ☐ Faxed to the requesting practice
- ☐ Sent by mail (post) to the requesting practice

Office Use Only:

Date copy sent:

Signature of Practice Representative: