Alpha Medical Centre Kwinana

08 9419 1400 **Fax** 08 9439 2705
T55 Kwinana Marketplace Shopping Centre
WA 6966 Kwinana Town Centre WA 6167

PO Box 336
Kwinana

Transfer of Records Form

Date of request: _____

Request to: _____

Phone Number: _____

Fax Number: _____

Email: _____

Requesting: _____

We wish to advice you that the patient (s) below are now attending our Medical Centre. We acknowledge that there may be a fee and request that the patient is to be advised of any fees relating to the copy and Transfer of their medical records prior.

First Name:_____**Surname:**_____

Date of Birth:_____**Signature:** _____

.....

First Name:_____**Surname:**_____

Date of Birth:_____**Signature:** _____

.....

First Name:_____**Surname:**_____

Date of Birth:_____**Signature:** _____

.....

First Name:_____**Surname:**_____

Date of Birth:_____**Signature:** _____

Photo Copy of Photo ID Attached

#Please note: If you are sending the record by disk or USB, please send in XML format only.

We do however accept records via Post, Fax, Healthlink or Email.

Phone Number: 08 9419 1400 **Fax Number:** 08 9439 2705
T55 Kwinana Marketplace Shopping Centre
WA 6966 Kwinana Town Centre WA 6167
HealthLink: Kwinana 1

PO Box 336
Kwinana

Email: manager@alphamedicalkwinana.com.au