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| **REQUEST TO TRANSFER CLIENT MEDICAL RECORDS**  **TO ANOTHER MEDICAL PRACTICE** | |
| BCHS clients must complete this form if they would like their medical records transferred from BCHS to another Medical Practice. BCHS will respond to these requests under the requirements of the Health Records Act 2001 (Vic). | |
| **From:**  **Bendigo Community Health Services**  PO Box 1121, Bendigo Central 3552  Phone: (03) 5406 1200  Fax: (03) 5441 4200  Email: [inforequests@bchs.com.au](mailto:inforequests@bchs.com.au) | **To:**  Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred format: PDF / XML / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Client Details:** | |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Information Requested (please tick ONLY one):** | |
| ☐ Full medical record  ☐ Health summary, including medications and immunisations only  ☐ Health summary, including medications, immunisations, correspondence and investigations from the last 3 months only  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| Please note that medical record transfer requests are generally considered non-urgent and will be prioritised for action against other urgent client information requests. Please allow up to 20 working days for this request to be actioned. Please ensure that all requested information is completed in order for this request to be actioned in a timely manner. |
| **Client or Authorised Representative Consent:** |
| I, (Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ authorise the release of my own medical records as detailed above.  ☐ am the authorised representative for the above client and authorise the release of their medical records as detailed above.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| REQUEST TO TRANSFER MEDICAL RECORDS TO ANOTHER MEDICAL PRACTICE FORM | 1 | Date of last review: Jun 2023 |