BERRI MEDICAL CLINIC

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Quality Practice Accreditation

# Transfer of Medical Records

Date: _____

Doctor / Specialist: _____

Surgery / Clinic: _____

Postal Address: _____

_____

Phone: _____ Fax: _____

**PLEASE PROVIDE MEDICAL RECORDS FOR:**

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Doctor Concerned,

The above patient(s) are currently seeking medical treatment at this clinic and they have requested that we obtain their past records.

We would appreciate it if you could forward their records at your earliest convenience.

*****Please do not send original notes or notes via disk. *****

**PLEASE ADVISE IF THE FOLLOWING HISTORY IS APPLICABLE INCLUDING DATE OF SERVICE:**

**GPMP** (721 / 723) _____

**TCA** (723) _____

**HMR** (900) _____

**Health Assessment** (705 / 707) _____

**MHP** (2700 / 2701, 2715 / 2717) _____

Thank you for your help.

_____ _____

**Patient Signature** **Doctor Signature**