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## TRANSFER OF PATIENT RECORDS

Dear Dr. \_\_\_\_\_ of \_\_\_\_\_

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The person of persons below are attending our practice now. We would appreciate it very much if you could forward us a complete medical record for continuity of care.

IT IS PREFERRED IF YOU CAN SEND US THE INFORMATION IN A DISC IN XML FORMAT

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Patient Name \_\_\_\_\_ DOB \_\_\_\_\_  
Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address \_\_\_\_\_

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Patient Authority : I Authorize the release of the above medical record to doctors at the Hayens Medical Centre

Patient/ Parent/Guardian Signature \_\_\_\_\_

Attending Doctors Signature \_\_\_\_\_