

CAMBRIDGE FAMILY HEALTH

MEDICAL RECORDS TRANSFER REQUEST

Each person 16 years or over to sign

I agree to Cambridge Family Health obtaining my medical records from my previous doctor.
I also understand that I will be removed from their practice register.

Date: ____/____/____

To: _____
(previous doctor / medical centre)

Fax: _____
(office use)

Address: _____
(of previous medical centre)

Please transfer the medical records for the following people to Cambridge Family Health.
Each person 16 years or over to sign.

Family Name	Given Names	DOB or NHI	Signature *of person(s) over 16

Please forward to Dr Prabani Wood : 40137

Our practice is able to receive and would prefer electronic GP2GP notes transfer.

Our EDI is: **cambrfam**

Office Use Only:	Paper Notes received	Yes	N/A
	GP2GP received	Yes	N/A