Cockburn Medical Centre
Individual, all-round care.

Dr Clive Lacey M.B.B.S. (W.A.), Cert. Sports Med., M.R.A.C.G.P.
Dr Li Yen Lee M.B.B.S. (Lond.)
Dr Chris Chin M.B.B.S. (W.A.), F.A.M.A.C.
Dr Monica Lacey M.B.B.S. (W.A.), F.R.A.C.G.P.
Dr Shashi Singh M.B.B.S., M.P.H., F.R.A.C.G.P
Dr Rikki Priest M.B.B. S (Hons)., M.R.AC.G.P.
Dr Bree Wright M.B.B.S. (W.A), F.R.A.C.G.P.
Dr Ivan Lee M.B.B.S. (Hons), F.R.A.C.G.P.
Dr Darryl Lacey M.B.B.S (W.A.)
Dr Deepak Panneerselvam M.B.B.S, F.R.A.C.G.P
Dr Carolin Behrens M.B.B.S, F.R.A.C.G. P
Dr Max Bowater M.B. B.S. (WA)

TRANSFER OF MEDICAL RECORDS IN- CONSENT FORM

I, _____ (Name of Patient)

of, _____ (Address of Patient)

_____ Post Code_____

_____ (Date of Birth)

hereby authorise, _____ (Name of Previous GP and Practice)

_____

to release my patient held record / summary and forward it to

COCKBURN MEDICAL CENTRE
SHOP 15/432 ROCKINGHAM ROAD, SPEARWOOD, WA 6163
PH: (08) 9418 3722 FAX: (08) 9434 1167

_____ Patient Signature

_____/_____/_____ Date

FAMILY MEMEBRS TO BE INCLUDED

	PATIENT'S NAME	DATE OF BIRTH	ADDRESS	SIGNATURE OF THE PATIENT/GUARDIAN
1				
2				
3				

TRANSFER OF MEDICAL RECORD CONSENT FORM
OFFICE USE ONLY
Signature of Practice Representative: _____

Designation of the Practice representative: _____

Date sent: _____

Please note that we use Best Practice software and prefer discs in XML format.