FTMC GROUP
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PATIENT MEDICAL RECORDS REQUEST

Date: _____

Previous Practice: _____

Practice phone number: _____

Practice email address: _____

Patient Name: _____

Date of Birth: _____

The above patient has requested their medical records held at your practice to be forwarded to FTMC Group. It would be appreciated if you could forward the relevant information to us. Our preference is for records to be sent via EMAIL or USB in XML FORMAT (no paper files please).

IF YOU WISH TO CHARGE A FEE FOR THIS SERVICE, PLEASE CONTACT THE PATIENT DIRECTLY FOR PAYMENT

I _____ hereby give consent for my medical records to be released to FTMC Group.

Patient signature _____ Date _____

Complete Record ☐ Health Summary ☐

Can you please also advise dates of last (if applicable): Health Assessment _____

GP Care Plan _____ Mental Health Plan _____

Please remove this patient from your practice on My Medicare if applicable