WINDMILL HILL MEDICAL

Transfer Authority Form

I .....

hereby authorise my current practice .....

to transfer the medical records and future appointments for myself and the people I am legally responsible for to Windmill Hill Medical at 13 High Street, Launceston.

Please provide dates of when Care Plans and Health Assessments were last billed.

FULL NAME	ADDRESS	DATE OF BIRTH

Yours sincerely,

.....

(your signature and date)

Please send to:
Windmill Hill Medical
admin@windmillhillmedical.com
or **PO Box 1193 Launceston TAS 7250**
or **fax 6776 0081**