

REQUEST FOR TRANSFER OF MEDICAL RECORD/S

I, _____,

DOB: ____/____/____

request a copy of my medical record/s to be

transferred to _____

Patient's Signature: _____

If under 18 years of age: Parent/Guardian's Signature:

Date: ____/____/____

Psychologists

Jacquelyn Furey
2597244B

Anita Gardner
4985815X

Jasmin Jambrak
4792586K

Walter Kiris
2869587T

Anissa Mouti
4538483J

Prof Stephen Touyz
2579849A

Clare Williams
4693686J

Psychiatrists

Dr Chris Rikard-Bell
033375BL

Dr Philippa Levy
403282ET

Dr Ian Sherman
058562GA

Dr Peter Vaux
044763LJ

Prof Garry Walter
044464PW

Medical, Dietetic, Psychosocial

Prof Michael Kohn
042999HT

Prof Simon Clarke
0022359X

Dr Samantha Hattle
4106563B

Dr Jane Ho
220100NB

Elizabeth Frig
4365426B

Vicki Hewson
2679523L