persistent pain solutions

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REQUEST FOR TRANSFER OF PATIENT MEDICAL RECORDS

As the patient listed below now attends this practice, please forward a copy of their medical records (or a complete and accurate health summary) and any other relevant clinical information to assist in the continued management of their healthcare.

Patient name: _____

Address: _____

Date of Birth: _____

PATIENT CONSENT

I, _____ consent to the release of my

medical records and any other relevant clinical information to Persistent Pain Solutions.

Patient name: _____

Signature: _____Date:_____

If not patient signing – name: _____

Your relationship to patient: (e.g. Mother, Father, guardian, carer) _____

Yours sincerely,

The Persistent Pain Solutions team.