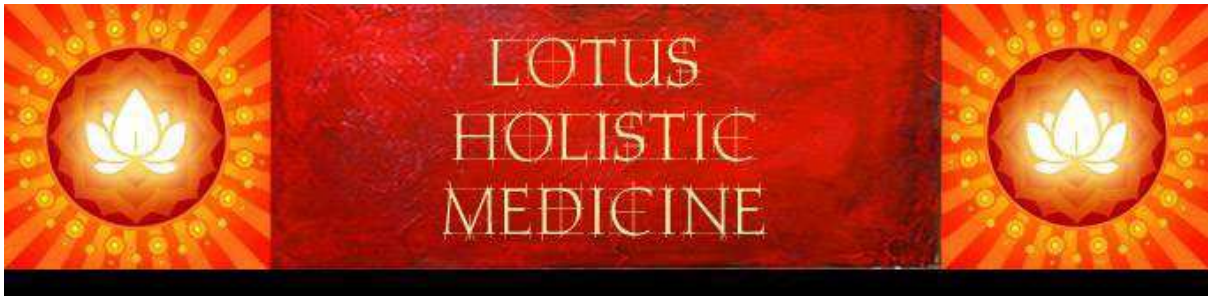

Medical Records Transfer Consent Form

I, _____
(Client's Full Name)

Date of Birth: ____ / ____ / _____

of _____
(Client's Address)

consent to _____
(Current/Previous Medical Practice Name)

_____
(Current/Previous Medical Practice Address)

releasing my medical records to Dr Sandeep Gupta of Lotus Holistic Medicine, Buderim.

I acknowledge that these medical records may include confidential information.

I acknowledge that Dr Gupta's clinic will act according to professional confidentiality guidelines and may share isolated medical information with other practitioners involved in my care.

Signed: _____

Full name _____

Date: ____ / ____ / _____

Clinic: 16/102 Burnett Street Buderim 4556 | **Phone:** (07) 5352 3468 | **Email:** admin@lotusholisticmedicine.com.au | **Book Online:** www.lotusholisticmedicine.com.au
Postal: P.O. Box 1113 Buderim 4556 | **Fax:** (07) 5302 6468 | **Blog:** www.drsandeepgupta.com | **Facebook:** Lotus Holistic Medicine