William Angliss Institute Medical Centre
Medical Alliance Pty Ltd.
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Dr Emil Popordanoski
Provider No.2607366W

William Angliss Institute Medical Centre
Medical Records Transfer and Access Form

Please email your completed and signed form **only** to
waimedicalrecords@gmail.com

With the closure of the WAI Medical Centre, this form provides us authority to:

- transfer your medical record to a treating practitioner/clinic as nominated by you **OR**
- provide a copy of your health record directly to you

Patient FIRST name and FAMILY name (CAPITAL LETTERS):	Date of birth:
Current Address:	
Previous address (if applicable): Email address:	
Telephone (home):	Mobile:

Other family members (if under 16 years of age)

Patient name:	Date of birth:
Patient name:	Date of birth:

Only select 1 of the following options:

☐ **Transfer medical records to my nominated practitioner/clinic**

Practice name:
Address: E-mail: Phone:

☐ **Provide a copy of my medical record directly to me**

Your medical record will be securely emailed to you in a password-protected file.

Patient signature:	Date:

Please email your completed and signed form **only** to
waimedicalrecords@gmail.com

WAI MC admin use only: Date Received: Received by (Staff initials):
Records use only: Date Received: Received by (Staff initials):