



Medical Records Transfer Consent Form

I, _____
(Client's Name)

Date of Birth: ____ / ____ / _____

of _____
(Client's Address)

consent to _____
(Medical Practice Name)

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: ____ / ____ / _____