TRICHOME MEDICINAL DISPENSARY

3/75 HARDGRAVE RD, WEST END QLD 4101 TEL NO: 07 3844 2543

Transfer of Medical Summary

Patient Information

Full Name:_____ Date of Birth: _____

Current Address: _____

_____

Phone Number: _____

Email Address: _____

Current Healthcare Provider (Sender)

Healthcare Facility/Hospital: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Email: _____

New Healthcare Provider (Recipient)

Trichome Medicinal Dispensary

Address: 3/75 Hardgrave Road, West End QLD 4101

Phone Number: 07 3844 2543

Email: info@trichomemedicinaldispensary.com.au

Patient/Legal Representative Consent:

I have read and understood this authorization for the transfer of medical records and voluntarily consent to its terms.

Patient Name: _____

Signature: _____

Date: _____