I …………………………… ………………….

wish to continue my medical care with **Dr Robert Schattner.**

I give consent for my medical records to be released to him.

DOB………………..

ADDRESS……………………………………

 ……………………………….

 ………………………………

PATIENT ( or N.O.K.) Signature………………………………

 Date:………………………………….

Patient previous Clinic/GP……………………………………

 Address:…………………………………………….

 Phone:…………………………….

 Fax:………………………………..

Please release all existing records in XML format