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