



Suite 2 & 3 Birubi Chambers
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Hawker ACT 2614
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To Dr _____ at _____

I am / we are now attending Hawker Medical Practice and seeing Dr _____

Please send a copy of my / our file to the below address. I understand that a fee may be charged for this service. Please include the file/files for the following children. I do understand that a separate form is to be signed for any person over the age of 16.

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Full Name: _____ DOB: _____

Signature: _____

HMP only can accept files in XML format, Via disc, USB or email
Paper copies will not be accepted.
Thank you