



I, (Patient Name) \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Would like my personal health files to be transferred to Cath Minter of Flora Medicine

Patient Signature: \_\_\_\_\_

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Date: \_\_\_\_\_