

# Request for Personal Health Information

## 1 (a) Patient Details (please print in block letters)

<b>Surname:</b>	<b>Given name(s):</b>
<b>Address:</b>	
<b>Date of birth:</b>	

## 1 (b) Applicant

<b>Applicant name:</b> (if not the patient)	<b>Relationship:</b> (to patient)
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## 2. Health Information Requested(please tick)

<input type="checkbox"/>	Pathology Results	Specify dates:
<input type="checkbox"/>	X-Ray Results	Specify dates:
<input type="checkbox"/>	Other Test Results	Please specify:
<input type="checkbox"/>	A Summary of My Health Record	
<input type="checkbox"/>	Health Record – detailed	
<input type="checkbox"/>	Current medications	
<input type="checkbox"/>	Correspondence on file	
<input type="checkbox"/>	Other	Please give details:

## 3. How would you like to receive this information?

<input type="checkbox"/>	View and inspect information. I will make a time with reception	
<input type="checkbox"/>	View, inspect & discuss contents with my doctor. I will make an appointment at reception.	
<input type="checkbox"/>	Obtain a copy - collect in person	
<input type="checkbox"/>	Obtain a copy - send via registered mail	
<input type="checkbox"/>	Obtain a copy	via fax no:
<input type="checkbox"/>	Obtain a copy	via email:

<b>Signature of Applicant</b>	<b>Date</b>
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**Note:** Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.

**Fee:** A fee of \$10 will apply for the retrieval and copying of your medical record. This fee covers the cost of administration as well as registered post. This fee is not redeemable through Medicare