

REQUEST FOR PERSONAL HEALTH INFORMATION

PATIENT DETAILS

Surname Given Name/s

Address

.....Date of Birth

Reason for request:

Health Information Requested: Please indicate

- ☐ Blood Test Results. Most recent? Y/N or specify date/s
- ☐ X-Ray Results. Most recent? Y/N or specify dates/
- ☐ Other Test Results. Please specify
- ☐ A Summary of My Health Record
- ☐ Health Record
- ☐ Other. Please give details

How would you like to receive this information?

- ☐ View and inspect information. I will make a time with reception.
- ☐ View, inspect & talk through contents with my doctor. I will make an appointment.
- ☐ Obtain a copy, I will collect it.
- ☐ Obtain a copy - Please send it to me via mail ☐ or email with password protection ☐

Signature of Applicant Date

Office Use Only	Staff to initial & date each entry
<input type="checkbox"/> Date request received	<input type="checkbox"/> Acknowledged date
<input type="checkbox"/> Personal ID sighted <i>licence/passport/other:</i>	
<input type="checkbox"/> Pension or Health Care Card Y/N	
<input type="checkbox"/> Appointment made with doctor? Y/N Date & Time	
<input type="checkbox"/> Patient to collect Expected Date	
<input type="checkbox"/> Doctor advised	<input type="checkbox"/> Noted in patient record
<input type="checkbox"/> Record checked & ready for patient	<input type="checkbox"/> Data Removed/deleted Y/N
<input type="checkbox"/> Method of access: View/View & Dr/Copy & collect/Copy & send	
<input type="checkbox"/> Fee Charged? Y/N Amount \$ _____ (excl GST)	Fee Received \$ _____
<input type="checkbox"/> Access process complete (record viewed/sent) Date	