



Practice Name
Address
Phone and Fax numbers

REQUEST FOR PERSONAL HEALTH INFORMATION

1. Patient Details

Family Name _____ Given Name _____
 Address _____
 _____ Date of Birth _____

2. Health Information Requested. Please tick your request

- _____ Test results
- _____ X-Ray results
- _____ Other results – please specify _____
- _____ A summary of health record – please specify _____
- _____ Complete health record
- _____ Other – please specify _____

3. How would you like to receive this information? Please tick your choice

- _____ View and inspect information – I will make a time with reception
- _____ View, inspect and talk through contents with my doctor. I will make an appointment at reception
- _____ A paper copy – I will pick up from reception
- _____ A paper copy – please forward by mail
- _____ Copy forwarded by email to _____
- _____ Copy forwarded by fax to _____

Fees may be charged for providing this information

Signature of Applicant _____ Date _____

<i>Office Use Only</i>	<i>Staff to initial & date each entry</i>
<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 _____	