McKinnon Hill Medical Centre

Request for Personal Health Information from _____

1 (a) Patient Details (please print in block letters)	
Surname:	**Given name(s):**
Address:	
Date of birth:	

1 (b) Applicant	
Applicant name: (if not the patient)	**Relationship:** (to patient)

2. Health Information Requested (please tick)		
☐	Pathology Results	Specify dates:
☐	X-Ray Results	Specify dates:
☐	Other Test Results	Please specify:
☐	A Summary of My Health Record	
☐	Health Record – detailed	
☐	Current medications	
☐	Correspondence on file	
☐	Other	Please give details:

3. How would you like to receive this information?	
☐	View and inspect information. I will make a time with reception
☐	View, inspect & discuss contents with my doctor. I will make an appointment at reception.
☐	Obtain a copy - collect
☐	Obtain a copy - send via mail
☐	Obtain a copy via fax no:
☐	Obtain a copy via email:

Patient consent: I , ..., hereby request and authorise you to release my Personal Health Information.

Signature of Applicant **Date**

Note: Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.

Charging policy: Fees may be charged for access please request information about our charging policy.

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