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:

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.

You will need the latest version of Acrobat Reader to submit this form online. Alternatively, you may also fill up this form online, download it as a PDF, and email us at **info@mckinnonhillmc.com.au

Submit

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