BRICKWORKS MEDICAL CENTRE
Shop 39, 2 Ashwin Parade, Torrensville, SA 5031
Ph: 08 7160 1187 Fax: 08 71601189

Personal Health Information Request Form

Patient details: *(please print in block letters)*

Surname: **Given name(s):**

Address:

Date of birth:

Applicant: *(if not the patient)*

Name: **Relationship to patient:**

Health information requested: *(please tick)*

What information is requested?

- ☐ Pathology results - ***specify dates:***
- ☐ X-ray results - ***specify dates:***
- ☐ Other test results - ***specify:***
- ☐ All correspondence on file
- ☐ A summary of health record
- ☐ Complete health record at any time to the present time
- ☐ Current medications
- ☐ Other – ***specify:***

How would you like to receive this information?

- ☐ View, inspect and discuss contents with my doctor. I will make an appointment with reception.
- ☐ Obtain a copy - collect
- ☐ Obtain a copy - send via mail to the address indicated above*
- ☐ Obtain a copy – send via fax to this number _____ * (for smaller files only)
- ☐ Send to other practice or address: _____

**Where health information is requested to be sent by mail, fax, or email, please sign the following declaration:* By signing this form I accept that my/the patient's privacy and confidentiality may be compromised by having personal health information sent by the method as selected and accept these associated risks.

I _____ (full name)
of_____ (current address) authorise the release of my medical records to _____ (clinic name/address) or give to me or _____ (person's name)

_____

Patient/Applicant Signature: **Date:**

In accordance with Australian Privacy Principle 12, we accept that our practice will, on request by an individual, give the individual access to their personal information, unless an exemption applies. ***Practice requires the upfront fee to process this request. Fees are applicable $60 per patient or $90 per patient***

if more than 100 pages. Please note that requests may take up to 8 weeks to process and Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.

If you are applying on behalf of someone else, you must provide documentation which clearly shows that you are the closest relative to the subject of the application E.G Birth certificate, death certificate or copy of court orders. You must provide written authorisation from the closest relative permitting you to access the information

Are you applying information about another person? Yes or No
If you answered yes, please give details of the other person:
Family Name: _____
Given Name: _____
Date of Birth: _____
Relationship to Patient: _____

Patient's name and Signature to release information to the applicant of this request:
_____

Applicant's Signature: _____

_____

Doctor's name: _____

Doctor's signature (to approve this request and release the information) _____

Date: _____