



Request for Personal Health Information Sandy Hill Medical Centre

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)
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2. Health Information Requested(please tick)

<input type="checkbox"/>	Pathology Results	Specify dates:
<input type="checkbox"/>	X-Ray Results	Specify dates:
<input type="checkbox"/>	Other Test Results	Please specify:
<input type="checkbox"/>	A Summary of My Health Record	
<input type="checkbox"/>	Health Record – detailed	
<input type="checkbox"/>	Current medications	
<input type="checkbox"/>	Correspondence on file	
<input type="checkbox"/>	Other	Please give details:

3. How would you like to receive this information?

<input type="checkbox"/>	View and inspect information. I will make a time with reception	
<input type="checkbox"/>	View, inspect & discuss contents with my doctor. I will make an appointment at reception.	
<input type="checkbox"/>	Obtain a copy - collect	
<input type="checkbox"/>	Obtain a copy - send via mail	
<input type="checkbox"/>	Obtain a copy	via fax no:
<input type="checkbox"/>	Obtain a copy	via email:

Signature of Applicant	Date
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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.