Patient Health Information Request Form

Details of the patient

Surname_____ Given Name _____ Title _____

Address _____

Date of Birth _____ Phone number during work hours _____

If you are not the patient, please give your details below

Please note: If the applicant is not the patient of the request for personal information then the consent of the patient must be provided.

Surname_____ Given Name _____ Title _____

Practice / Hospital / Other _____

Phone no _____ Fax no _____

Date _____

Urgency of request: (please circle) Urgent Next day Non-urgent

Information sent by (please circle) fax registered post in person

Information required (please tick and specify dates)

O Discharge summary _____

O Health summary _____

O Specialist letters _____

O Operation report _____

O Investigations _____

O Other _____

Patient consent (please tick & sign as appropriate)

O I, the above named patient, consent to to the release of my health information to the healthcare provider making the request. I understand this is necessary to assist in my ongoing treatment.

Patient signature: _____

O It is impracticable to provide patient consent at the time of this request. I verify that I am treating this patient and require the information for their ongoing treatment.

Doctor signature: _____

Office use only:

Date & time request received: _____ Staff receiving request _____

Information sent by (please circle) fax registered post in person