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:**
Previous Clinic Details where details are to be requested from:	
Clinic Name:	☐
Clinic Fax:	☐
What information is requested? *(please tick)*	☐ 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 ☐ Current medications ☐ Other – ***specify:*** _____

How would you like to receive this information?

☐ Obtain a copy - collect

☐ Obtain a copy - send via mail: 7/175 Ocean Drive Twin Waters Qld 4564

☐ Obtain a copy – send via email to this email address: admin@twinwatersmedical.com.au

☐ Obtain a copy – send via medical objects

I, _____ ***(full name),*** 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.

Patient/Applicant Signature: _____ **Date: _____**

In accordance with Australian Privacy Principle 12, we accept that our practice must, on request by an individual, give the individual access to their personal information, unless an exemption applies. For further information, refer to the Office of the Australian Information Commissioner website: www.oaic.gov.au