Request to access medical record

I *(name)*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

of *(address)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
date of birth ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(please tick one)
□ request access to my medical record,

□ in person *(an appointment for a consultation with the doctor is made)*

□ in printed format

□ in digital format *(you will need to provide a USB, we can’t email your health information to you)*

□ give consent for *(enter your doctor’s or health provider’s name here)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be provided with

□ my whole medical record

□ a summary of my medical record

□ the specific documents listed below

□ test results

□ letters from the specialist to my referring doctor
List of documents required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
I have been advised of the applicable administration fee for this service, charged in accordance Health Records Regulations 2002 (Vic), which is not redeemable via Medicare. I understand the Practice may request I attend a consultation with my doctor to discuss the information contained in my medical record.  In this instance, a consultation fee will apply which is not redeemable via Medicare.
I understand I will not be permitted to remove, amend or delete any contents from my medical record.  If I wish to make any amendments or deletions, I must submit a request in writing to the Practice using the Request to Amend Medical Record Form. I understand I am permitted to obtain copies of some or all of the contents of my medical record. Copies may not be available immediately at the time of inspection but will be made available to me as soon as practicable after the inspection.
Signature of patient or parent/guardian of patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date  \_\_\_\_\_\_\_\_\_\_