Request for copy of patient medical records

ForHealth

Centre | **Date**

Patient information

Full name | Date of birth

Address

Email

Patient declaration

I,

request that a copy of the Medical Records / Clinical notes or a Summary of my Medical history be provided to the Doctor / person whose details I have indicated below.

The specific Medical Records / Clinical Notes I require are:

Records transferred from:

Name of doctor | Name of practice

Address

Suburb / Postcode

Phone number | Fax number

Records transferred to:

Name of person / GP | Name of practice

Address

Suburb / Postcode

Phone number | Fax number

Authorisation

I understand and accept that there is a reasonable fee for this process which covers printing, photocopying and administrative charges.

Signature of person / patient requesting:

Requirements if patient is 13 and under:

+ Signature of both parents/guardians
+ Birth certificate
+ Signed ID of both parents/guardians

Sig 1.

Sig 2.

Patient ID is required when the patient is completing this form.

Return this form to the medical centre either in person or via email (with a digital copy of signed ID attached) for processing.