Lockridge Medical Centre
Building a Healthier Community

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Personal Health Information Request Form

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

Patient details: *(please print in block letters)*

Surname: **Given name(s):**

Address:

Date of birth:

Applicant: *(if not the patient)*

Name: **Relationship to patient:**

Health information requested: *(please tick)*

What information is requested?

- ☐ 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?

- ☐ View and inspect information. I will make an appointment with reception.
- ☐ View, inspect and discuss contents with my doctor. I will make an appointment with reception.
- ☐ Obtain a **COPY in person** - **collect** *(Valid ID must be present and sign to confirm received upon collection)*

**Where health information is requested to be sent by mail, fax or email, please sign the following declaration:*

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**