



<<Your Practice Name>>

**REQUEST FOR PERSONAL HEALTH INFORMATION**

**1. Patient Details**

Family Name \_\_\_\_\_ Given Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Date of Birth \_\_\_\_\_

**2. Health Information requested. Please tick  your request**

- Test results
- X-Ray results
- Other results - please specify \_\_\_\_\_
- A summary of health record - please specify \_\_\_\_\_
- Complete health record
- Other - please specify \_\_\_\_\_

**3. How would you like to receive this information? Please tick  your choice**

- View, inspect and talk through contents with my doctor. I will make an appointment at reception.
- Paper copies of my medical records, after I have viewed the contents with my doctor. I will make an appointment at reception.
- A paper copy of the summary of my health record
  - Please forward by mail
  - I will pick up from reception
  - Copy forwarded by fax to \_\_\_\_\_
  - Copy forwarded by email to \_\_\_\_\_

*Fees may be charged for providing this information*

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

| Office use only   | Staff to initial and date each entry | NPP  |
|---|--------------------------------------|--|
| Date request received _____   |                                      | <input type="checkbox"/> Acknowledged date |
| <input type="checkbox"/> Personal ID sighted licence/passport/other _____ |                                      |  |
| <input type="checkbox"/> Pension or Health Care Card Y/N                  |                                      |  |
| <input type="checkbox"/> Appointment made with doctor? Y/N                | Date & Time _____                    | Dr _____                                   |
| <input type="checkbox"/> Patient to collect                               | Expected Date _____                  |  |
| <input type="checkbox"/> Doctor advised                                   | Noted in Patient Record              |  |
| <input type="checkbox"/> Record checked and ready for patient             |                                      |  |
| <input type="checkbox"/> Fee Charged? Y/N                                 | Amount \$ _____ (excl GST)           | Fee Received \$ _____                      |
| <input type="checkbox"/> Access Process Completed (Record viewed / Sent)  | Date _____                           |  |
| <input type="checkbox"/> Staff Member Signature for Completion            | _____                                |  |