

## Patient Information Access Form

### Patient Details

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Medicare: \_\_\_\_\_ Reference \_\_\_\_\_ Expiry: \_\_\_\_\_

As outlined in the National Privacy Principle 6 (NPP 6), I wish to access the following information from my medical health records, stored at Medika Health Clinic:

☐ Medication List ☐ Full Record ☐ Billing History

☐ Consultation Notes Please provide date range \_\_\_\_\_ to \_\_\_\_\_

☐ Pathology Results Please provide required tests

\_\_\_\_\_  
\_\_\_\_\_

☐ Imaging Results Please provide required tests

\_\_\_\_\_  
\_\_\_\_\_

☐ Other Please specify

\_\_\_\_\_  
\_\_\_\_\_

I am aware that I am unable to obtain specialist letters from the Practice. Requests for the release of specialist reports will need to be obtained from the specialist directly. We are happy to provide you with the relevant contact information and documentation and can fax it directly to the specialist on your behalf.

I am aware that I may be charged a small fee for printing and that the fee is determined on a case-by-case basis.

I have provided my photo identification to permit Medika Health Clinic to keep a photocopy for record keeping purposes.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Photo ID Type & Number*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Expiry Date*