MEDIKA HEALTH CLINIC
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Authority to Release Information

Patient Details

Name: _____ DOB: _____

Address: _____

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 and for those records to be released to:

Name: _____

Email: _____

☐ Medication List ☐ Full Record ☐ Billing History

☐ Consultation Notes Please specify date range _____ to _____

☐ Pathology Results Please specify required tests

_____

_____

☐ Imaging Results Please specify 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.

_____ _____

Patient Name *Patient Signature*

_____

Date