

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