



Medika Health Clinic

Modern, GP-led healthcare

Comprehensive.

Considered.

Care.

Contact

4/476 Wanneroo Road
Westminster WA 6061
08 6186 0283
info@medikahealth.com.au
medikahealth.com.au

Patient Medical Records Release & Access Consent Form

Comprehensive. Considered. Care.

PATIENT DETAILS

Full name	
Date of birth	___ / ___ / ___
Address	
Phone / Email	

REQUEST PURPOSE

☐ Personal access	☐ Transfer to another general practice
☐ Specialist care	☐ Insurance or compensation
☐ Legal matter	☐ Other: _____

INFORMATION REQUESTED

☐ Complete medical record	☐ Health summary only
☐ Consultation notes	☐ Pathology / imaging results
☐ Referrals / specialist letters	☐ Care plans
☐ Other: _____	☐ Date range: ___ / ___ / ___ to ___ / ___ / ___

METHOD OF ACCESS OR RELEASE

☐ View at practice	☐ Secure email with ☐ PDF ☐ XML
☐ Secure messaging	☐ Mail / collection
☐ Send to authorised recipient below	☐ USB ☐ Disc

AUTHORISED RECIPIENT

Complete only if records are to be released to another person or organisation.

Practice / organisation	
Doctor / contact	
Address	
Email / phone	
Secure messaging	

PATIENT CONSENT

I authorise Medika Health Clinic to provide access to my health information and/or release the information specified above to the authorised recipient listed in this form.

I acknowledge that my identity may be verified; a reasonable administration fee may apply; the original record remains with Medika Health Clinic; this consent applies only to the information specified; and I may withdraw consent in writing before release.

Patient signature	
Date	___ / ___ / ___

AUTHORISED REPRESENTATIVE

Complete only if signed by a parent, guardian, executor or legal representative.

Representative name		
Relationship to patient		
☐ Parent / guardian	☐ Power of attorney	
☐ Executor	☐ Other: _____	
Evidence sighted		
Representative signature		
Date	____ / ____ / ____	

PRACTICE USE ONLY

Identity verified by		
Date verified	____ / ____ / ____	
Identification sighted:		
☐ Driver's licence	☐ Passport	
☐ Medicare card	☐ Other: _____	
Request approved by		
Date completed	____ / ____ / ____	
Method of release:		
☐ Secure email	☐ Secure messaging	
☐ Mail	☐ Collection	
☐ Other: _____	☐ USB ☐ Disc	
Records released to		
Recorded in patient file	☐ Yes ☐ No	
Administration fee	☐ N/A ☐ Quoted ☐ Paid	

IMPORTANT INFORMATION

Medika Health Clinic protects your personal health information. Only authorised team members may access it for your care or legitimate practice operations. Information is not disclosed without consent unless required or authorised by law.

We may ask to sight identification or evidence of a representative's authority. A reasonable fee may apply. If access is restricted or refused, written reasons and available complaint options will be provided where required.

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Please return the completed form to the Practice Manager.