Access to Health Records Request Form

Patient Details

- Full Name: _____
- Date of Birth: ____ / ____ / _____
- Address: _____
- Contact Number: _____
- Email: _____

Type of Request

☐ Access to my **full health record**

☐ Access to **specific documents/reports** (please specify):

☐ Request for a **health summary** only

☐ Request for information to be released to a **third party** (requires signed consent section below)

Preferred Method of Access

☐ View in person at the clinic
☐ Printed copy (collection in person)
☐ Electronic copy (secure encrypted email/portal)
☐ Other: _____

Identity Verification

Please provide one of the following (sighted by staff):
☐ Driver's Licence
☐ Passport
☐ Medicare Card
☐ Other ID: _____

Staff initials: _____ Date: ____ / ____ / _____

Third-Party Access (if applicable) – You will be asked to complete an additional consent to release records/information form when release is to a 3rd party also.

I authorise *The Doctors Hope Island* to release my health information to

Name of Organisation/Person: _____

Address/Email: _____

Reason for Access: _____

Patient Signature: _____ Date: ____ / ____ / _____

Acknowledgement of Fees

I acknowledge that:

- There is **no fee to lodge this request**.
- A **reasonable fee** may be charged for printing, staff time, or postage.
- I will be advised of any charges before my request is processed.

☐ I agree to proceed with the request and pay any applicable fees.

Patient Signature: _____ Date: ____ / ____ / _____

Clinic Use Only

- Request received by: _____ (Staff Name)
- Date received: ____ / ____ / _____
- Method: ☐ In person ☐ Email ☐ Post
- ID verified: ☐ Yes ☐ No
- Consent form attached (if applicable): ☐ Yes ☐ No

Outcome of Request:

☐ Full access granted
☐ Partial access granted (reason): _____
☐ Request refused (reason): _____

Processed by: _____ Date: ____ / ____ / _____

Notes: