**Request for Access to Medical Records**

**Patient Request Form**

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| **Information for Patients**  This practice provides patients access to medical records in accordance with the Privacy Act (1988) and Australian Privacy Principle #12, which deals with access to personal information.   1. Generally, the health service provider who creates a medical record owns that record. 2. You have a right to gain access to all the information held about you. You may exercise this right in a number of ways, e.g., 3. Looking over the records. 4. Taking a copy of those records with you. 5. Having them explained to you. 6. Due to the complex nature of most medical records, Clinical Precision would prefer to explain the content of your records to you. 7. There are some limitations on your right of access. These may apply, for example, to; 8. Where giving access would pose a serious threat to the life and health of anyone. 9. Where refusing access is required by law. 10. Clinical Precision will not include any original documentation from other health providers outside the practice. The patient should contact each practice separately. 11. **A written request is required to access your medical record.** |

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| **Patient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DOB** \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request access to my medical records held by Clinical Precision.

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| **Practitioner** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Reason for request** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Patient signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date** \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ |

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| **OFFICE USE ONLY** | | | | |
| **Photo identification** |  Driver’s License |  Passport | |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Reviewed by practitioner** \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ | | | | |
| **Information sent** \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_   Email  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Sent by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Date sent** \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ | |
| **Entered into patient record by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Date** \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ |