



Albert Road Clinic

Part of Ramsay Health Care

Request For Access to Patient Medical Records

URN: _____

Surname: _____

Given Name: _____

D.O.B: _____ Gender: _____

(Affix Patient Identification label here)

In accordance with the Health Records Act 2001 it may take a maximum of 45 days to respond to requests. Medical records relate to Albert Road Clinic patients only. Private consulting rooms records are the domain of the Psychiatrist.

1. Full Name of applicant: _____

Applicant's contact details:

a) Contact Telephone/mobile: _____

b) Postal Address: _____

Postcode: _____

2. Your relationship to the person requesting information:

☐ Self (please go to Question 3)

If not the patient, appropriate consent form or authority to access the medical record must be provided and attached to this form:

☐ Parent

☐ Relative (≥ 18 years and member of household)

☐ Spouse or de facto

☐ Enduring power of attorney – Medical / Financial

☐ Guardian

☐ Nominated by the patient to be contacted in an emergency

☐ Child/sibling (≥ 18 years of age)

☐ Other: _____

3. Patients Given and Surname at time of last admission: _____

Patient's date of birth: ____ / ____ / ____

Patient's Address at time of last admission: _____

4. Do you want access to all or part of the medical record: All ☐ Part ☐

Outline the nature of information required/documents required:

5. Do you wish to receive a copy of the information or review the information at the hospital?

☐ Receive a copy

☐ Review the information at the hospital

6. If a copy of the information requested is being sent to General Practitioner / Solicitor / Other, please provide recipients details:

a) Name: _____

b) Relationship: _____

c) Address: _____

d) State: _____ Postcode: _____

7. Please specify the preferred method of receiving a copy of the requested information:

☐ Mail (Please note, it is our usual practice to send the copy of the requested information by ordinary mail)

☐ Person (applicant)

☐ Person (by recipient nominated in Question 6)

You are required to supply a signed copy of photographic identification with this request (i.e. car licence, passport) prior to the request being processed by the hospital.

I acknowledge that there is a cost involved in processing my request and providing access to the requested information. I will be provided with an estimate of the administrative charge which is to be paid prior to gaining access to the required information.

Date: ____ / ____ / ____ Signature of patient: _____

Date: ____ / ____ / ____ Signature of applicant (if not patient): _____

REQUEST FOR ACCESS TO PATIENT MEDICAL RECORDS