winmante MEDICAL CENTRE

REQUEST FOR PERSONAL HEALTH INFORMATION

1(a) Patient Details

Name_____

Address _____

Date of Birth _____ Telephone Number_____

1(b) Applicant Details

Name (if not the patient)_____

Relationship to patient_____

2. Health Information Requested

- ☐ Pathology Results
- ☐ X-Ray Results
- ☐ Other Test Results. Please specify _____
- ☐ A Summary of My Health Record
- ☐ Health Record – detailed
- ☐ Current medications
- ☐ Correspondence on file
- ☐ Other. Please give details_____

3. How would you like to receive the information requested?

- ☐ View, inspect and discuss contents with my doctor. I will make an appointment at reception.
- ☐ Obtain a copy - collect
- ☐ Obtain a copy - send via registered mail

Note: Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.

Signature of Applicant _____ Date _____