Mater

Exceptional People. Exceptional Care.

Patient Request to Access Clinical Records

Unit Record No. _____

Surname _____

Given Names _____

D.O.B. _____ Sex: _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Section 1 – Details of patient

(Patient / Responsible Person to complete)

Name of patient		Date Requested	/ /

_____ hereby request a copy of the documents listed at 1 below.
(Name of Patient / Authorised Person)

Basis of authorisation if not the Patient:_____

Authorised person is a parent or guardian of a minor; a person appointed by power of attorney or advanced Health Directive; another person authorised by law; a person authorised in writing by the patient.

Address of Patient and Address of authorised Person (if different)			
		Post code	

Contact Phone Number(s)	
Business hours	
After hours	

Date of birth of Patient		Health Record UR (Mater Personnel to complete)	

1. Please list below the clinical information / documents required

2. Please explain the reason(s) why the documents are required

Provide ID
Certified copy of photographic ID, if you do not have photographic ID,
please Contact Privacy Coordinator on (07) 3840 2145

Section 2 – Acknowledgement of potential costs

(Patient/ Person Authorised to complete)

I understand that fess are associated with the processing and dispatching of the clinical records in accordance with my request and undertake to pay such fees prior to receiving the copies of the clinical records that I have requested.

I am not aware of any legal or other reason which prevents me from making this request nor any other person or Department that I must consult with before I make this request. There are no court orders in existence which limit my rights to access this information.

Name (Please print)			
Signature		Date	

Binding Margin – Do Not Write
Do Not Reproduce By Photocopying
All Clinical Form Creation And Amendments Must Be Conducted Through Health Information Services.

PATIENT REQUEST TO ACCESS CLINICAL RECORDS 1

02/07
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