perth Clinic

REQUEST TO ACCESS PATIENT INFORMATION

Surname:……

Given name……

MRN:……

DOB:……

SECTION 1 – Patient Details *(Patient to complete)*

Name of patient:	Date of Birth:
Address:	Post Code:

Contact Numbers:	Business Hrs:	After Hrs:	Mobile:

Specific nature of information and reason requested: (If insufficient space, please attach additional pages)

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Name: *(Please Print)* ……

Signature: …… Date: ……/……/……

SECTION 2 – Acknowledge of Potential Costs *(Patient to complete)*

Cost for copies of health information is $95.

I acknowledge that in the event that copies are made, there will be a cost involved and that payment will be required on/or prior to collection. I will be notified of the amount in due course.

Name: *(Please print)* ……

Signature: …… Date: ……/……/……

BINDNG MARGIN - DO NOT WRITE

REQUEST TO ACCESS PATIENT INFORMATION HR20

perth Clinic

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Surname:……..……..…

Given name……

MRN:…….……

DOB:……

SECTION 3– Approval for Release OFFICE USE ONLY								
Approval for Release:	☐ Yes	☐ No						
Reasons for denial/partial denial: …… …… …… …… ……								
Patient advised of decision:	☐ Yes	☐ No						
Appointment to view record made with:	Date:							
Copy of record required?	☐ Yes	☐ No	Amount Due:	$	Patient advised of fee:	☐ Yes	☐ No	
Name:	Title:	Signature:	Date:					
SECTION 4 – Distribution								
Patient ID sighted copied and certified:	☐ Yes	☐ No	☐ License ☐ Other ☐ Passport ……..					
Outcome of appointment: …… …… …… …… …… …… …… ……								
Copies taken: …… …… …… ……								
Patient signature on record review/collection:								
Total fee:	Method of payment: *(please circle)*	Cash	Cheque	Mastercard				
		VISA	AMEX	Other				
Name:	Title:	Signature:	Date:					