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: __________

c) Email: ______________________

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
☐ Spouse or de facto
☐ Guardian
☐ Child/sibling (> 18 years of age)
☐ Relative (> 18 years and member of household)
☐ Enduring power of attorney – Medical / Financial
☐ Nominated by the patient to be contacted in an emergency
☐ 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: __________

e) Email: ______________________

7. Please specify the preferred method of receiving a copy of the requested information: *Our preferred method of sending documents is via email. If you prefer to have a hard copy we can send via courier (courier charges will apply)*

☐ Email
☐ 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): ______________________

Please send the completed form either by post/fax or email to:

The Privacy Officer
Health Information Services Department
Ramsay Clinic Albert Road
31 Albert Road
Melbourne Vic 3004
Fax: 03 9256 8324
Email: healthinformations1@ramsayhealth.com.au

BINDING MARGIN - DO NOT WRITE

REQUEST FOR ACCESS TO PATIENT MEDICAL RECORDS