



A Service of the Sisters of the
 Little Company Mary with Values of
 Hospitality, Healing, Stewardship & Respect

REQUEST TO ACCESS A PATIENT RECORD

SECTION 1 – Details of Patient		
(Patient / Responsible Person to complete and return to Medical Record Department)		
Name of Patient:	Date Requested:	
<p>If patient is incapable of giving or communicating consent, health information may be provided to a responsible person as defined by the Act.</p> <p>Name of Responsible Person: _____</p> <p style="text-align: center;"><i>(Please tick relationship to patient, i.e. Guardian, Parent, Power of Attorney etc.)</i></p> <p style="text-align: center;"><i>Please provide photocopied proof of authorisation to access patient information prior to this request being processed</i></p> <p><input type="checkbox"/> Parent</p> <p><input type="checkbox"/> Child or Sibling > 18 years</p> <p><input type="checkbox"/> Spouse or De Facto Spouse</p> <p><input type="checkbox"/> Guardian</p> <p><input type="checkbox"/> Enduring Power of Attorney</p> <p><input type="checkbox"/> Intimate Personal Relationship with Patient</p> <p><input type="checkbox"/> Relative > 18 years and member of patient's household</p> <p><input type="checkbox"/> Person Nominated by the Individual to be contacted in case of Emergency</p> <p>Please specify reason why patient is incapable of giving / communicating consent:</p> <p>_____</p> <p>_____</p> <p>_____</p>		
Address:	Post Code:	
Date of Birth:	Phone Number Business Hours:	Phone Number After Hours:
Specific nature of information requested: (If insufficient space, please attach additional pages) _____ _____ _____ _____		
Signature: _____		
Date: _____		

Please Turn Over



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SECTION 2 – Acknowledgment of Potential Costs (Patient / Responsible Person to complete)

I acknowledge that in the event that I require an explanation of the record, or copies to be made, a maximum charge of \$35.00 will be applicable.

Name (Please Print) _____

Signature: _____

Date: _____

SECTION 3 – Consent to Notify Treating Doctor(s) (Patient / Responsible Person to complete)

I give consent for Calvary Healthcare Tasmania to notify my/the patients treating doctor(s) that I have made a request to access my/the patient's medical record.

Yes No

Signature: _____

Date: _____

SECTION 4 – Patient Records (Patient / Responsible Person to complete)

Requested information to be COLLECTED by (please tick)

Medical Practitioner Solicitor Health Fund Patient/Applicant Other (please specify)

OR POSTED to:

Medical Practitioner Solicitor Health Fund Patient/Applicant Other (please specify)

If to be posted, please complete name and address of person to whom information is to be sent and specify whether by ORDINARY or REGISTERED Mail:

Ordinary Mail Registered Mail

Requests will be processed in order of receipt, however records will be available within a maximum of **30** days.

In the event that you wish to collect your record in person, identification will be required prior to release.

Signature on collection: _____

Date: _____