HORIZON
FAMILY DOCTORS

Request for personal health information

1 (a) Patient Details (please print in block letters)	
Surname:	**Given name(s):**
Address:	
Date of birth:	

1 (b) Applicant	
Applicant name: (if not the patient)	**Relationship:** (to patient)

2. Health Information Requested (please tick)		
☐	Pathology Results	Specify dates:
☐	X-Ray Results	Specify dates:
☐	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 this information?	
☐	View and inspect information. I will make a time with reception
☐	View, inspect & discuss contents with my doctor. I will make an appointment at reception.
☐	Obtain a copy - collect
☐	Obtain a copy - send via mail
☐	Obtain a copy via fax no:
☐	Obtain a copy via email:

****Please note if you have requested your health information via email this must be approved by the provider before records can be sent.**

The Royal Australian College of General Practitioners (RACGP) Standards for General Practice acknowledge that patients are able to obtain advice or information related to their clinical care by telephone or electronic means where the doctor determines that this is clinically safe and that a face-to-face consultation is unnecessary[3]

Please note that transfer of health information via email is not secure. Encryption of email can only be successful when both parties have the appropriate programs on their computer. So, with this in mind, it is more likely that emails will be sent without encryption. Please be aware that the practice cannot guarantee confidentiality of information transferred via email.

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

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Office Use Only		
☐	Date request received:	
☐	Acknowledgement date:	
☐	Identification verified known to staff. Licence, passport or other:	
☐	Appointment made with doctor?	☐ Yes ☐ No Date: Time:
☐	Patient to collect.	Expected date:
☐	Doctor advised prior to release	
☐	Noted in patient record	
☐	Record checked & ready for patient	
☐	Data removed or deleted	☐ Yes ☐ No
☐	Method of access:	☐ View/View ☐ Dr/Copy ☐ Collect/Copy ☐ Send
☐	Fee Charged?	☐ Yes ☐ No Amount: $ *(excluding GST)*
☐	Access process complete (record viewed/sent)	Date:

Signature of Applicant	**Date**