growlife medical
patient | family | community

growmedical.com.au
ABN 21 614 209 031

Request for Personal Health Information

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

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:
☐	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 with my doctor
☐	Obtain a copy - collect
☐	Obtain a copy - send via secure email

Signature of Applicant	**Date**

Note: Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.
Charging policy: Fees may be charged for access please request information about our charging policy.

Office Use Only			
☐	Date request received:		
☐	Acknowledgement date:		
☐	Identification verified known to staff. Licence, passport or other:		
☐	Appointment made with doctor?	☐ Yes ☐ No Time:	Date:
☐	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 *(excluding GST)*	Amount: $
☐	Access process complete (record viewed/sent)	Date:	