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Request to Access Medical Records

I,.....(name & DOB)

of .....(street)

.....(suburb)

My entire medical record;
OR
I request that all documents relating to the diagnosis/treatment of the following condition/s: : .....

.....

be forwarded to: .....(treating Dr)

Address:.....

.....

Phone:.....Fax:.....Email:.....

to assist in the management of my health.

I enclose a signed Privacy Legislation Consent Form for your records and thank you in anticipation.

.....(signature)
Patient or parent/guardian of patient

.....(name)

Date:.....