



Request for Personal Health Information Form

Patients Name: _____

Patients Address: _____

Patients Date of Birth: _____

Please specify what information you required by ticking the following applicable boxes:

- Full comprehensive health record (all records held by this medical practice)
- Only records pertaining to the following condition/injury
- Health Summary (this will include a list of current medications, all past medical history, a list of any allergies or adverse reaction you have and immunisation history as per our records)
- Other (please specify below):

Further Details:

Please confirm how you would like us to deliver the records for you:

- Electronic copy on disc posted to (please advise address):
- Electronic copy on disc that I will collect from the practice
- Hard copy that I will collect from the practice

Please Note - An administrative fee may be payable for the provision of such information, and the current fee can be obtained by emailing privacy@oldbarmedical.com.au.

Patients Signature: _____

Date: _____