Old Bar Medical Centre

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

☐ - Covid Vaccine 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:

☐ - PDF via email to (please advise email address):

☐ - 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: _____

Old Bar Medical Centre
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