National Privacy Principles

REQUEST TO ACCESS MEDICAL RECORDS

I,_____of

_____request access

to or give consent to _____ to access

the entire contents of my medical record or the following documents (see form 'A' over).

I understand that I will not be permitted to remove the contents of my medical record from the premises of the medical practice, nor will I be permitted to alter or erase information contained in the medical record.

I understand that I will be permitted to obtain copies of some or all of the contents of my medical record. Where copies are requested, a fee will normally be applicable and will be payable in advance. Further, I understand that copies may not be available at the time of inspection of my medical record but will be made available to me as soon as practicable following the inspection.

*Signature of Patient :*_____

Date of Birth: _____ *Date*_____

*Signature of Person Given Consent By Patient:*_____

*Date:*_____

Particulars of Photographic Identification Provided: _____

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REQUEST TO ACCESS MEDICAL RECORDS

FORM A: Documents requested from medical file of: ……...

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Signature of patient: ……

Date: ……