



QUEENS PARK MEDICAL CENTRE

339 Wharf St, Queens Park WA 6107
 t 08 9356 8993 f 08 9356 8994
 www.queensparkmedical.com.au

PATIENT REQUEST FOR ACCESS OR RELEASE OF PERSONAL INFORMATION

Date: _____

To: _____ (Doctors Name)
 _____ (Medical Centre)
 _____ (Practice Phone Number) _____ (Practice Fax Number)

I _____ (full name) ____/____/____ (Date of Birth)
 of _____ Telephone: _____
 (Current Address)

Authorise release of my/my family's medical records to be forwarded to Queens Park Medical Centre and understand a reasonable fee may be charged for the cost of providing access or providing copies for which I am responsible.

Patients Signature: _____

Other Family Members (under 18 years of age)	DOB	REGULAR GP

The above mentioned now attends this practice. To assist in their future medical management would you kindly forward:

- Clinical Records _____
 (Please specify either period of visits to the doctor or reason why access is requested (eg records relating to a specific condition or injury))
- Current health summary, with relevant correspondence and results

These records can be forwarded by Healthlink ID: **queenspk**

Fax: 9356 8994

Post: Queens Park Medical Centre 339 Wharf Street QUEENS PARK WA 6107

If your practice uses Best Practice you can email electronic version of patient record in XML format to

reception@queensparkmedical.com.au