Health Information Services
Phone: 9288 2760 Fax: 9288 2785

Patient Information Request Form

Details of Requestor: *(Please complete details or use Doctor Stamp)*

Name: ....

Hospital/Practice/Other: ....

Phone No: .... **Fax No:** ....

Date: ....

Urgency of Request: *(Please circle)* **Urgent** **Next Day** **Non-Urgent** *Within 5 business days*

Patient Details:

Patient Name: ....

Address: ....

SVH UR No: .... **Sex:** M / F **DOB:** ....

Information Required: *(Please tick & specify dates if known)*

☐ **Discharge Summaries** ....

☐ **Outpatient Correspondence** ....

☐ **Operation Reports** ....

☐ **Investigations** ....

☐ **Other** ....

....

Patient Consent Details: *(Please tick & sign as appropriate)*

☐ *I, the above named patient consent to the release of health information (including test results etc) about past and present illness to the Doctor or health care provider making this request. I understand this is necessary for my ongoing treatment.*

....

Patient Signature

☐ *It is impracticable to provide patient consent at this time. I verify that I am treating this patient and the information is required for their ongoing treatment*

....

Doctor Signature

HIS Details:

Staff Receiving Request: .... **Date:** .... **Time:** ....

Information Sent By: *(Please circle)* **Fax** **Mail**

Staff Name: .... **Date:** ....

SVH endeavours to comply with the *Health Records Act 2001* and other relevant legislation when handling health information. The health information enclosed is being provided to your service on the understanding that is to be used for its primary purpose or for a directly related secondary purpose. Disclosure of this health information to your service imposes on you an obligation to treat this information confidentially and in accordance with legislative requirements of the *Health Records Act 2001*, *Privacy Act* and *Information Privacy Act 2000*.