REQUEST TO ACCESS OR TRANSFER INFORMATION FROM CLIENT RECORDS

To: IPC Health – Privacy Officer
PO Box 171, **DEER PARK VIC 3023**
E: privacy.officer@ipchealth.com.au

Patients Name: …….. **DOB: ……**

Address: ……..

If you are not the client, state your relationship to client i.e. Guardian, Parent: ……

Name:……

Please include the following family members
(*Patients 17 years or older need to sign their own consent forms)*

Patients Name: …….. **DOB: ……**

Patients Name: …….. **DOB: ……**

Please provide a copy of one of the following forms of PHOTO identification:

□ Drivers Licence □ Passport □ Other form of photo identification ……

Information Required:
Health Summary ☐ Medical History Last 2 years ☐

Other: ……

Information to be sent to:
**Note information can be sent via secure email*

Self ☐ **email address:……..**

General Practitioner ☐ **Solicitor** ☐ **Other** ☐

If record being transferred to external agency please provide details:

Name of Organisation:……

Email: ……..

Address: ……

ACKNOWLEDGMENT
I acknowledge that there is a cost involved in providing the requested information and that payment maybe required on/or prior to collection.

Signature: …… Date: ……..

In accordance with the Health Records Act 2001 individual requests are to be actioned within 45 days.

Information in this form will be kept in the strictest confidence and only used and disclosed for the purpose of administering this request.