# CAIRNS HEALTH COLLECTIVE

# REQUEST TO ACCESS MEDICAL RECORDS FORM

I, of ,

*request records for*

☐ Requesting access to my medical record or

☐ Requesting access to my child's medical record

☐ I Request access to the documents listed on the following pages, in

**Table A**.

I have been advised of the applicable administration fee for this service, which is not redeemable via Medicare.

I understand the Practice may request I attend a consultation with my doctor to discuss the information contained in my medical record. In this instance, a consultation fee will apply which may not be redeemable via Medicare.

I understand I will not be permitted to remove, amend or delete any contents from my medical record. If I wish to make any amendments or deletions, I must submit a request in writing to the Practice using the *Request to Amend Medical Record Form*.

I understand I am permitted to obtain copies of some or all of the contents of my medical record. Copies may not be available immediately at the time of inspection but will be made available to me as soon as practicable after the inspection.

Under the *Privacy Act 1988* (Cth) and the *AAP* you have a legal right to access the personal information that Stratford Medical Centre holds about you/children (such as your medical record), subject to some exceptions.

**Access Fees**

The Practice is entitled to charge an appropriate fee, , to cover the administrative costs of this service. Our reception will advise you of the applicable fee, which is not redeemable under Medicare or private health insurance.

**How do I request Access to my Personal Information?**

Patients who wish to access or obtain a copy of their personal information should put their request in writing using the attached *Request to Access Personal Information Form*, and submit the form to our Practice reception. All requests will be acknowledged in writing within 14 days of receipt of the request. Ordinarily, access to the requested information will be provided within 30 days.

**How will Access be Provided?**

Access may be provided by:

- inspecting your medical record at the Practice.; and/or
- providing a copy of the requested information in person or
- providing an accurate summary of the information, instead of a copy, if you and the doctor agree that a summary is appropriate.

We recommend that you make an appointment with your doctor to view your medical record together, so the doctor can assist you to understand and interpret the material contained within it. A consultation fee will apply in addition to the administration fee, plus GST. The fee may not be redeemable via Medicare or private health insurance.

**Can I Amend my Medical Record?**

You will not be permitted to remove any contents of your medical record from the Practice. Should you wish to amend or delete any personal information, you will need to fill out a separate written request using the *Request to Amend Medical Record Form* available from reception.

**When will Access to My Medical Record be Refused?**

Access to your personal information may be legitimately withheld in certain situations, including (among others):

where access would pose a serious threat to the life, health or safety of any individual or the public;

- where access would cause unreasonable impact on the privacy of other individuals;
- where the request is frivolous or vexatious; or
- where the information is privileged as a result of actual or anticipated legal proceedings.

If access to your personal information is refused, the Practice will provide you with written reasons for the refusal. You will not be charged an access fee in this instance. If access is refused, you are welcome to contact the Practice to discuss means by which access may be facilitated.

If you have any queries regarding the above policy, please contact our Practice Manager who will be happy to discuss these with you.

Table A - List of requested

☐ entire medical record;

or

☐ all documents relating to the diagnosis/treatment of the following condition/s;

(*please briefly describe condition/s*)

1.
2.
3.
4.
5.

and/or

☐ the following documents:

(*please describe documents requested*)

1.
2.
3.
4.
5.

This record must be collected from the Pracitce. The record will be made available on a usb stick.

Dated Signed _____

If appliable please sign below

**If requesting access, to your child's record, please confirm the following**
**I Guardian name confirm**

1. **there is no court order to the contrary to any member of the family who may be mentioned in this file**
2. **The child is not a mature minor , gillick compentent or 15 years or older**

**Dated** **Signed**

***Parent/guardian of patient***

ID Checked Copy taken

Witnessed -

| Records Collected | Sign | Date |
| --- | --- | --- |