Calvary

Calvary John James Hospital
173 Strickland Crescent, Deakin ACT 2600
P: (02) 6281 8122
F: (02) 6281 8771

REQUEST FOR ACCESS TO MEDICAL RECORDS

I, ______________________________ request access to my medical record which covers the treatment received over the period ______________ to ______________

MY PERSONAL DETAILS ARE AS FOLLOWS:

Last Name: ______________ First Name: ______________

Mr/Mrs/Ms/Other: ______________ Date of Birth: ______________

Address: ______________________________

TELEPHONE: (Work) ______________ (Home) ______________

I wish to: (Please tick)

☐ View the record

☐ Obtain a copy of the record

☐ View the record and have the contents explained

Signature ______________ Date ______________

Fee and processing information:

A fee of $48.75 will apply to all request for first 50 pages, plus 40c per page thereafter. Payment information will be provided following form submission, please allow at least 1 week after account has been processed to receive your medical records.

OFFICE USE ONLY

Approved ☐ Yes ☐ No

Comments ______________________________

Approved by: ______________

No copies sent ______________ Date sent ______________

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