Calvary Central Districts Hospital
REQUEST FORM FOR ACCESS TO PATIENT RECORD

SECTION ONE- APPLICANT DETAILS

1. Name of Applicant:______________________________

(Please go to question four if you are applying for access to information that Calvary Health Care holds about you)

2. What is your relationship to the subject of the requested information?

☐ Parent ☐ Relative (>18 years & member of subject's household)

☐ Spouse or De Facto ☐ Exercising enduring power of attorney

☐ Guardian ☐ Nominated by the subject to be contacted in an emergency

☐ Child or Sibling (>18 years of age) ☐ Intimate personal relationship with subject

☐ Treating Medical Practitioner

3. Reason for application to access documents

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4. Applicant's contact details:

a) Contact numbers:______________(home)______________(work)

b) Address: ______________________________

______________State ______________Postcode ______________

I acknowledge that there may be an administrative charge involved in processing my request and providing access to the requested information. I will be provided with an estimate of the administrative charge which is to be paid prior to gaining access to the requested information.

Date: ______________ ______________
Signature of applicant

Date: ______________ ______________
Signature of Patient