Health Records Access Form

For clients requesting access to or transfer of health records out of Your Community Health.

Please complete this form and return it to Your Community Health, with all necessary documents attached.
Mail or in person: 125 Blake Street, Reservoir, VIC 3073 | **Email**: info@yourch.org.au | **Fax**: 8470 1107

Fees: There may be costs associated with this application, in line with Health Records Regulations 2023.

SECTION 1: Your details (the applicant) We collect your details so that we can respond to your application. We will only use your details for this purpose. Your application may be affected if your full details are not provided.	First name: _____ Surname: _____ Date of birth: _____/_____/_____ Postal Address: _____ State: _____ Postcode: _____ Phone number: _____ Email: _____ **Have you provided a copy of your identification with this application?** (e.g. Australian Drivers' License, passport, or a certified copy of your Medicare Card, Health Care Card, Pension Card or Veteran Card) Yes ☐ No ☐

SECTION 2: Client details We need to know whose health information you are seeking. We require proof that you have the authority to access health information about another person.	**Are you seeking access to information about yourself or other people?** Myself ☐ (skip to Section 3) Other people ☐
	If you are seeking access to someone else's records, please provide their details: First name: _____ Surname: _____ Other names known by (if applicable): _____ Date of birth: _____/_____/_____ Relationship to you: _____ Postal Address: _____ State: _____ Postcode: _____ Phone number: _____
	Does this person know you are requesting access to their records? Yes ☐ No ☐
	Is this person deceased? Yes ☐ No ☐

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SECTION 3: Details of the request You have the right to access your health record and request correction to information. The decision to grant access will be based on legislation and the health privacy principles. For more information, please see the "Keeping your information private" flyer and the "Client Information Privacy Policy" on our website.	**What is the reason for your request? (e.g. moving to a new practice, insurance claim, personal reference etc.)** _____ _____ _____
	Do you want to access all or part of the record? Medical ☐ Allied Health ☐ Dental ☐ All records ☐ Specific documents ☐
	If you are requesting specific documents (or documents from a specific date range), please specify: _____ _____ _____

SECTION 4: How to access the record You can choose how you would prefer us to release the record.	**Would you like to access the record or transfer to another organisation (e.g. doctor, lawyer, insurance company)?** Transfer the record ☐ (skip to section 5) Access the record ☐ Both ☐
	If you are accessing the record yourself, how would you like to do this? a) **Receive a copy** of the health record ☐ If selecting a), please tick how would you like to receive the record: Paper copy sent by registered post ☐ Digital copy sent via secure email ☐ Paper copy collected from one of our sites (please indicate site below) ☐ b) **View the record** at one of the Your Community Health site/s ☐ If selecting b), please tick your preferred site/s: East Reservoir ☐ Preston (PANCH) ☐ Northcote ☐

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SECTION 5: Transferring the record We need to know where to send the record.	**If you are requesting the record to be sent to another organisation, please provide details:** Name of contact person (if applicable): _____ Name of organisation: _____ Postal Address: _____ Phone number: _____ Fax number: _____ Email: _____ If known, please tick the preferred way to receive the record: Fax ☐ Paper copy sent by registered post ☐ Digital copy sent via secure email ☐

Checklist	**Have you included all the necessary documentation to process this application?** Australian Drivers License / Passport / Medicare Card / Concession Card ☐ If requesting information about another person: Proof of authority e.g. Medical Power of Attorney, Consent to Share ☐ If requesting information about a deceased person: Proof of legal representation e.g. Grant of Probate, Grant of Letter of Administration ☐

Your signature (the applicant)	**I declare that, to the best of my knowledge, I have completed this form correctly and have consent to access these health records.** Signature: _____ Name: _____ Date: _____/_____/_____

Next Steps	We will assess your request in accordance with the Health Records Act 2001 and we will contact you within 45 days of receiving this form. If you have any further queries or require assistance in completing this form, please contact the Health Information Officer on (03) 8470 1111. Information about our privacy policy can be found on our website: www.yourch.org.au/about-us/privacy-and-confidentiality/