Health Services

Curtin University

Date: ___________________________

To:

Doctor/Medical Practice: ____

Tel: ____

Fax: ____

E-mail: ____

Re: Patient Request for Access or Release of Medical Records

The patient below now attends Curtin University Health Service, and we would like to request a copy of their clinical records to assist in the continued management of their healthcare.

Patient's Full Name: ____

Patient's Date of Birth: ____

Patient's Address: ____

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Our Practice uses Best Practice Software and we prefer an electronic copy of the records in XML format via email (HSManager@curtin.edu.au).

Patient Consent

I, ____ consent to the release of my full medical records and any other relevant clinical information to Curtin University Health Service as I am now attending this practice.

Patient's Full Name: ____

Patient's Signature: ____

Name of parent/guardian: ____

Signature of parent/guardian: ____