

Patient Details

Given name(s):

Surname:

Previous names (if any):

Date of birth:

Phone:

Email:

Address:

Requestor Details *(if person seeking access is different to the patient)*

Given name(s):

Surname:

Phone:

Email:

Relationship with patient:

Details of Medical Records Requested

Scan details

Scan date(s) or period(s):

Scan type(s) (e.g., MRI, X-Ray):

I would like:

- Images only
 Report(s) only
 Images & Reports

Form of access

Secured electronic copy. The email address to securely send the records to is:

Hardcopy. The details (name and address) for records to be posted are:

Authority to access records

I have authority to request access to the records described above because *(please select **one** of the following that applies)*.

- I am the patient
- I am the parent or legal guardian of the patient
- I am the Executor or Administrator of the deceased patient's estate
Please attach evidence of the Grant of Probate or Grant of Letters of Administration.
- I have authority to make decisions for the patient on their behalf, as the patient does not have decision making capacity
Please attach evidence of Enduring Power of Attorney, Enduring Guardianship or other authority which allows you to access the patient's medical records.
- Other

Patient's Consent

I give my consent for I-MED to provide the medical records detailed above to the Requestor named above:

Patient	Signature:	Print name:
	Witness signature:	Witness name:
	Date:	
Parent or Legal Guardian <i>(if patient is under 14 yrs old)</i>	Signature:	Print name:
	Witness signature:	Witness name:
	Date:	

Requestor's Signature *(if person seeking access is different to the patient)*

Requestor	Signature:	Print name:
	Witness signature:	Witness name:
	Date:	

Please note:

- A witness must be 18 yrs or older, must not be the Patient or Requestor, must not be a family member of the Patient or Requestor, and must be physically present and witness the Patient and Requestor signing this form.
- Costs: I-MED may charge a reasonable fee for providing access, where the fee will be reflective of the costs incurred by I-MED. You will be advised of these costs (if any) after receipt of your request. If you have queries about the costs, please discuss these with us.
- In some cases, access to medical records may be restricted due to specified circumstances in the Privacy Act. If your request falls within one of these stated exceptions, we will provide you with an explanation as to why access cannot be granted and to discuss if there is an alternative that will meet your requirements.

For Staff Use Only

Patient consent provided	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A
Authority cited (if applicable)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A
Costs of access discussed (if applicable)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A
PACS/Visit No:			
Records provided on (date):		by (staff member's name):	
Clinic / office location:			
Any additional notes:			