Request for Access To or Correction Of Patient Records

|  |  |
| --- | --- |
| **Patient** |  |
| **Address** |  |
| **DOB** |  |
| **Telephone / Email** |  |

**Health Information Requested**

|  |  |  |
| --- | --- | --- |
| Please tick form of access requested | Inspection  Copy | Explanation or accurate summary  Correction |
| Please describe the records to which access is requested or what correction is requested |  | |

Depending on the type of access you request, you may be charged a fee in accordance with applicable laws.

To ensure compliance with Federal and State Privacy Legislation, we require signed consent to authorise access to these records.

See also our practice privacy policy available at [www.specialneedsdental.com.au/forms/](http://www.specialneedsdental.com.au/forms/) .

**AUTHORITY FOR RELEASE OF RECORDS**

|  |  |
| --- | --- |
| **Details of patient/person responsible for medical treatment decisions** | |
| **Name** |  |
| **Relationship to the patient** |  |
| **Address** |  |
| **Telephone / Email** |  |

I …………………………………… …………………………………give permission for the Special Needs Dental Team to release/correct the information as requested above. I have been advised of the fees involved and agree to pay them.

|  |  |  |  |
| --- | --- | --- | --- |
| Please forward the records to: | | OR | I wish to pick up the records from the practice on the following date \_\_\_/\_\_\_\_/\_\_\_\_  (Please allow 7 days) |
| Name |  |
| Address |  |
| Fax/Email |  |

Signature: ………………………………………………………… Date: ……………………………………….