Patient Information Request Form

NORTHSIDE CLINIC

Patient Name: _____ Date of Birth: _____

Address: _____ Postcode: _____

I, the above patient consent to the release of health information regarding my previous care at the practice detailed below to Northside Clinic. I understand this is necessary for my ongoing treatment.

Patient Signature: _____ Date: _____

Name (if different to the patient): _____

Relationship to the patient: _____

Previous Provider

Provider Name: _____

Hospital/Practice/Other: _____

Phone Number: _____ Fax Number: _____

Urgency of Request: Urgent Next Day Non-Urgent (within 5 days)

We accept transfers via encrypted email in XML format for Best Practice to admin@northsideclinic.net.au

Northside Clinic

Attention: _____

370 St. Georges Road, North Fitzroy VIC 3068

Fax: (03) 9486 5718

Please note: If you are sending via CD we prefer XML format as we use Best Practice. PDFs must be no larger than 6MB for inputting, so please split large PDF files

Northside Clinic endeavours to comply with the Health Records Act 2001 and other relevant legislation when handling health information. The health information enclosed is being provided to your service on the understanding that it is to be used for its primary purpose or for a directly related secondary purpose. Disclosure of the health information to your service imposes on you an obligation to treat this information confidentially and in accordance with legislative requirements of the Health Records Act 2001, Privacy Act and Information Privacy Act 2000.