St. Andrews Health

35 Caledonia Street
St. Andrews, VICTORIA 3761
Phone: 1300 100 724 (SAH)
Fax: 03 8669 4154
Email: contact@standrewshealth.com.au
https://standrewshealth.com.au/

Request for Release of Personal Health Information

Patient details

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss ☐ Dr ☐ Prof ☐ Other
Family name	
Given name/s	
Date of birth	/ /
Address	

Details of previous clinic to transfer records from

Clinic name		
Clinic address		
Clinic phone		Clinic fax

Details of receiving St. Andrews Health Doctor *(Please note: St. Andrews Health does not accept information on CDs, DVDs)*

I request that a copy of my medical history or summary be forwarded to:

Doctor name		
Clinic name	St. Andrews Health Service, St. Andrews VIC	
Clinic phone	1300 100 724	Clinic Fax: 03 8669 4154
Please tick if completed and record the date of the last assessment or review for this patient	Assessment or review: ☐ GPMP or mental health ☐ TCA ☐ Diabetes plan ☐ Asthma plan ☐ Medication review ☐ Other health check ☐ CMA	Date completed: / / / / / / / / / / / / / /

Family members to include in transfer *(Signature only required if family member is 16 years or older)*			
Name	D.O.B / /	Signature
Name	D.O.B / /	Signature
Name	D.O.B / /	Signature
Name	D.O.B / /	Signature
Name	D.O.B / /	Signature
Name	D.O.B / /	Signature

I understand that a fee may be charged for the cost of providing access or copies. The record can be faxed or sent via registered post to the receiving clinic detailed above. **I hereby authorize release of my medical history to St. Andrews Health Service.**

Signature of person requesting: _____ Date: ___/___/____