



Gungahlin Medical Centre

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Gungahlin ACT 2912
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Fax(02) 6134 6745

ACCESS TO MEDICAL RECORDS OR RESULTS

Patient's name:

Patient's address:

Patient's phone number: Patient's date of birth:

- I request access to the documents listed below
- I agree to provide proof of identification of myself before access is provided
- I am aware that a photocopying fee may apply

Date of Records <i>if known</i>	Records / Results Requested

Further notes:
.....
.....
.....

Patient's Signature: Date:

Office Use Only

Date of last visit:

Name of treating doctor:

Doctor's Signature: Date: