I-MED Radiology Network

Comprehensive care. Uncompromising quality.

Request Form

Medical Record Access

Details:

Clinic name and address: .....

.....

Name of person seeking access: .....

Name of patient (if not the person seeking access)*: .....

Relationship with patient (if not the person seeking access): .....

Medical record(s) required (eg CT images and report for x date): .....

Form of access required (eg photocopy, electronic file, summary, viewing, explanation): .....

Records to be collected on or required by (date/time): .....

Records to be posted/emailed/faxed to (name, details): .....

.....

Costs: No charge will be made to lodge this request for access. However, in providing access to you, this clinic may incur charges arising out of: retrieval of records from archives, doctor's time to peruse the records, photocopying charges, doctor's time for explanation (which is not Medicare or private health insurance funded). If you have any queries regarding the costs of your request for access, please discuss these with us.

Please note: 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 could not be granted and to discuss if there is another alternative that will meet your requirements.

..... / /

Signature of person seeking access Date

For Staff Use Only

Acknowledgement of access request provided	◯ Yes	◯ No	◯ N/A
Costs of access discussed	◯ Yes	◯ No	◯ N/A
* Signed consent obtained from patient (only if third party requesting)	◯ Yes	◯ No	◯ N/A
** Access granted after identity confirmed / denied (refer to Privacy Policy for exceptions)	◯ Yes	◯ No	

PACS/Visit No .....

Records provided on (date) / / by (staff member's name) .....

Clinic location .....