**Request to Access Health Information**

Please use this form when requesting a copy of your **personal health information** held with LCHS or Link



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| --- |
| **Client Name:** |
| **Address:** |
| **State: Phone: DOB: / /** |
| **Email:** |

*All fields must be completed for form to be processed*

|  |  |
| --- | --- |
| Obtain a copy of the documents | Inspect the documents |

I would like to:

**The documents I wish to access relate to:**

|  |  |
| --- | --- |
| Allied health : Diabetes / Dietitian / Podiatry / Occupational Therapy etc. | Dental history |
| Alcohol & drug treatment / counselling | Dental **imaging only** |
| General practitioner (GP) | Other – please give details below |
|  | |

**If you are not the client to whom the request relates, please complete the following:**

|  |  |  |
| --- | --- | --- |
| Your relationship to the client (*please tick*) | Parent | Legal Guardian |
| Other – please provide details: |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date of Birth:** | / / |
| **Phone number:** |  |  |  |

**Supporting documentation:**

1. Where you are requesting access to records other than your own, you may be required to provide evidence of your authority to do this.
2. Your identity can be confirmed in person at a centre via sighting your photo ID or please attach a copy of your photo ID when emailing or posting in your form.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature:**  (or signature of parent\guardian) |  | **Date:** | / / |
| **Print name:** |  |  |  |

|  |  |  |
| --- | --- | --- |
| 🖳 **Email to:**  records@lchs.com.au | 🖂 Mail to:  Records Management  PO Box 960 Morwell Vic 3840 | ✆ Phone:  1800 242 696  Ask for Records Management Office |