



Health Information Services  
Phone: 4215 1171 Fax: 4215 1242  
Patient Information Request Form

**Details of Requestor:** *(where available please use GP stamp)*

Name: .....

Practice/Hospital/Other: .....

Phone No: ..... Fax No: .....

Date: .....

Urgency of Request: *(please circle)*      Urgent      Next Day      Non-urgent  
*Within 5 business days*

**Details of Patient:**

Patient Name: .....

Address: .....

BH Hospital UR No:                      Sex: M/F                      DOB: .....

**Information Required:** *(please tick and specify dates)*

- Discharge Summaries.....
- Outpatients Letters .....
- Operation Reports .....
- Investigations: *(specify if known)* .....
- ED Discharge Letters .....
- Other .....

- Patient Consents:** *(please tick & sign as appropriate)*  
I, the above named patient, consent to the release of my health information to the health care provider making this request. I understand this is necessary to assist with my ongoing treatment.  
**Patient Signature:**.....
- I, the above named patient, authorise Baron Health to record the above named GP and practice as my usual GP for the release of all future correspondence  
**Patient Signature:**.....
- It is impracticable to provide patient consent at the time of this request. I verify that I am treating this patient and require the information for their ongoing treatment.  
**Doctor's Signature:**.....

**HIS Use Only:**

Date & Time request received:.....Staff receiving request: .....

Information sent by: *(please circle)* Auto download Fax Other *(please specify)* .....

Staff name: ..... Date: .....

*The health information is being provided to your service on the understanding that it will be used for its primary purpose or for a directly related secondary purpose. Your service has an obligation to treat this information confidentially and in accordance with legislation contained within the Health Records Act 2001 and Information Privacy Act 2000.*