National Health Co-op
Better Health Together

Phone: (02) 6178 0400
Fax: (02) 6259 3101
email: reception@nhc.coop
Website: www.nhc.coop
PO Box 521 Jamison Centre ACT 2614

Medical Record Access Form
(Record Release to Patient)

Patient Details

First name:	
Surname:	
Date of birth:	
Address (in Australia):	
Contact phone number:	

I hereby request the release of my medical records held by the National Health Co-op.

Record Request

Do you require access to all or part of your medical record? (please tick one): ☐ All ☐ Part
If partial access is required, describe clearly the documents you require:

Record Delivery

How would you like the records to be sent?

☐ Post (Australian addresses only)	*Postal address:*
☐ Email	*Email address:*

If you have selected to receive your records via email, please note the following:
The National Health Co-op does not currently support communications through email due to the difficulty associated with ensuring the confidentiality of information communicated through this medium. By signing this document, you acknowledge an understanding of the risks associated with your personal information being transmitted through an unsecure medium and you agree to indemnify the National Health Co-op against any negative outcomes resulting from this medium of transmission.

Signature: _____ **Date:** _____/_____/_____
All patients over the age of 16 must sign.

OFFICE USE ONLY:
Name: Date: ☐ Photo ID sighted