



Northside Clinic
Patient Information Request Form

Patient Details

Patient Name

Date of Birth

Address

I, the above named patient consent to the release of health information regarding my previous care at the practice detailed below to Northside Clinic. I understand this is necessary for my ongoing treatment.

Patients Signature

Date

Name: (if different to the patient)

Relationship to the patient

Previous Provider Details

Provider Name

Hospital/Practice/other

Phone Fax

Urgency of request Urgent Next Day Non-Urgent (within 5 business days)

Please post a CD, fax or use secure electronic encryption to send the medical records to:

Northside Clinic
Attention:
370 St Georges Road Fitzroy North VIC 3068
Fax 03 9486 5718

Results can be sent via argus on argus@northsideclinic.net.au or via healthlink

Please Note: If you are sending via CD we can only accept PDF or Genie Format.

Northside Clinic endeavours to comply with the Health records Act 2001 and other relevant legislation when handling health information. The health information enclosed is being provided to your service on the understanding that it is to be used for its primary purpose or for a directly related secondary purpose. Disclosure of this health information to your service imposes on you an obligation to treat this information confidentially and in accordance with legislative requirements of the Health Records Act 2001, Privacy Act and Information Privacy Act 2000