Request for Original Medical Record Release

Under Section 7 of the *Health Records (Privacy and Access) Act 1997*

DR VINH DUC LIEU *(363054K) of* ***202/222 City Walk Canberra City ACT 2601***
Phone: (02) 6257 3555 Fax: (02) 6249 8034 Email: v@lieu.com.au

For Dr Lieu Office Use
File number: _____
Date received: _____
Date sent: _____
Tracking no.:

Patient Details

Given Name: _____ Surname: _____

Date of Birth: _____ / _____ / _____ Phone: _____

Street Address: _____

Suburb: _____ State: _____ Postcode: _____

New Health Service Provider

Doctor Given Name: _____ Surname: _____

Provider number: _____ Phone: _____

Postal Address: _____

Suburb: _____ State: _____ Postcode: _____

Request

Please release the patient's original medical records rendered by **DR VINH DUC LIEU**. This information will be used to further assist in the patient's medical care.

Patient Authorisation

I am authorised to access the medical records because (*please tick*):

- ☐ I am the patient.
- ☐ I have the patient's/parent's/guardian's written consent *(please attach evidence).*
- ☐ I am the patient's next of kin (*only applicable where the consumer is a minor, or for compassionate reasons where the patient is deceased*).
- ☐ I am the Legal Guardian, Executor of the Will or have Power of Attorney *(please attach evidence)*. Parent/Guardian consent needed if patient is under 18 years of age.

Requestor's Consent

I hereby authorise **DR VINH DUC LIEU** to release my original medical records to the new health service provider named on this form.

Name: _____

Signature _____

Date: _____ / _____ / _____

Post, scan or fax this form to the address above.

New Health Care Provider's Consent

I will hereby accept the original medical records for the above named patient under my care. I understand this may take up to 4 weeks from the date of Dr Lieu receiving this form.

Are these files medically urgent? YES / NO **(pls circle)**

Name: _____

Signature _____

Date: _____ / _____ / _____