

**PATIENT REQUEST FOR ACCESS OR RELEASE
OF PERSONAL HEALTH INFORMATION
FROM A GENERAL PRACTICE
(Incorporating requirements of Privacy Legislation)**

ROKEBY GP

**PLEASE DO NOT FAX MEDICAL NOTES.
WE PREFER PATIENT RECORDS ON CD THAT ARE IN XML FORMAT TO BE USED WITH
BEST PRACTICE SOFTWARE. THANK YOU**

Patients Name _____

Date of Birth _____

Patient Address _____

Patient records are currently at

Name of Practice _____

Address _____

Telephone _____

Fax _____

To the above named Practice

I am currently a patient at Rokeby GP

I authorise my complete Health record to be released to Dr _____

at Rokeby GP

Patient or parent/guardian's signature _____

Date _____