Dr Mark Doudle
B.M.B.S. F.R.A.C.S.
Specialist Colorectal Surgeon

REQUEST TO ACCESS MEDICAL RECORDS

(held by Dr Mark Doudle)

I, _____

of _____

request access to or give consent to _____

to access the entire contents of my medical record or the following documents.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I understand that I will not be permitted to have unsupervised access nor remove the contents of my medical record from the premises of the medical practice.
I also understand that I will not be permitted to alter or erase information contained in the medical record.

I understand that I will be permitted to obtain copies of some or all of the contents of my medical record. Where copies are requested, a fee of $3.30 (inc GST) is applicable. Further, I understand that copies may not be available at the time of inspection of my medical record and will be made available to me as soon as practicable following the inspection.

Signature of Patient: _____

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

A MINIMUM 3 WORKING DAYS IS REQUIRED FOR PROCESSING THIS REQUEST