

REQUEST TO ACCESS HEALTH INFORMATION

Send this form to:

Records Management Officer
Latrobe Community Health Service
PO Box 960
Morwell Vic 3840

Surname	
First Name (s)	
Date of birth:	

Postal Address		Post Code	
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Phone Contact No – Home	
Business	

I would like to access the following document (s):

Indicate whether you would like to inspect the documents or obtain a copy of the documents:

I want to inspect the document (s)..... Yes / No (Circle whichever applies)

I want a copy of the document (s)..... Yes / No (Circle whichever applies)

Signature:.....

Date:

Office Use Only

Registration No:

Date Request Received: .../.../....

Received By: