DOC NO. MHFRM.7.352	Patient Request for Disclosure of Patient Health Summary for Covid-19 Vaccination	MARKETOWN HEALTH

Dear Patient

Marketown Heath may only disclose your Personal Health Information to a third party with your written consent to the disclosure of that information. You must provide 3 types of identification before information will be released to the third party nominated by you.

Please complete this form and attach copies of your ID documents and return it to informationofficer@marketownhealth.com.au.

Patient Name:	
Patient Date of Birth:	
Date:	
Is this for Covid-19 Vaccination Only:	☐ Yes ☐ No
Name of General Practitioner with whom the Patient's Personal Health information is to be shared:	
Fax number of practice: **YOU MUST PROVIDE A FAX NUMBER** **Or the records will not be sent**	
Patients Signature:	
Witness Name:	
Witness Signature:	
Date:	

NOTE: We do not accept electronic signatures.
If this document is not completed properly your Patient Health Summary will not be sent.
Please ensure that you request your records at least 24 hours before your vaccination appointment.

Office Use Only

☐ 3 points of ID provided by the patient
☐ File faxed on date: ……