Consent to Access Health Information

PATIENT DETAILS	
PATIENT'S FULL NAME:	
PATIENT NHI:	
PATIENT ADDRESS:	

By signing this document, I consent and give authorisation for my pharmacist to obtain my medical records including accessing my hospital records.

I understand the purpose is to assist with optimising my health management.

I understand my information will not be copied or stored and only records that are relevant to my care will be accessed.

PATIENT SIGNATURE: **DATE:**

PHARMACY DETAILS	
Consent Obtained by:	*Pharmacist Name and Signature*

This Information is to be used by:

Pharmacy:

Address: *Insert Pharmacy Stamp*

We will comply with the Privacy Act 2020, the Health Information Privacy Code 2020 when collecting, using and managing personal information.

Under the Privacy Act 2020 and Health Information Privacy Code 2020, you have the right to access any information we hold about you. You can also ask us to correct the information that we hold about you.