



## MELBOURNE PODIATRISTS & ORTHOTICS MEDICAL RECORDS REQUEST FORM

Please email this completed form to [reception@mpao.com.au](mailto:reception@mpao.com.au)

For more information visit:

<https://www.melbournepodiatristsandorthotics.com.au/resouces/medical-records-request>

### Important Information

Melbourne Podiatrists & Orthotics is legally allowed up to **45 days** from the receipt of a written request to provide medical records. However, in most cases, we aim to process requests within **2 weeks**.

### Patient Details

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email (for invoices, if applicable): \_\_\_\_\_

### Request Details

I am requesting records as a:

- Patient
- Legal Representative
- Physician/Healthcare Provider
- Insurance Company
- Other: \_\_\_\_\_

If not the patient, please complete the following:

- Patient consent obtained (*please attach signed patient authorisation*)
- Legal requirement (*please attach relevant documentation*)

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email (for invoices): \_\_\_\_\_



### Type of Records Requested

- Complimentary one-page summary letter (*patient requests only*)
- Full copy of medical records (*fees apply*)

### Purpose of Request

- Continuing Medical Care
- Personal Use
- Insurance
- Legal
- Other: \_\_\_\_\_

### Fees

Fees for full medical records are outlined on our website. GST applies to all third-party requests. Invoices will be sent to the email provided above. Records will only be released once full payment is received.

### Delivery Method

- **One-page summary letters:** delivered via email
- **Full medical records:** Delivered via secure, password-protected Dropbox link to the email provided.

Email Address for Delivery: \_\_\_\_\_

### Authorization

I hereby authorise Melbourne Podiatrists & Orthotics to release the specified medical records as outlined above.

### Signature of Patient or Legal Representative:

\_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

If signed by Legal Representative, indicate relationship:

- Parent  Guardian  Power of Attorney  Other: \_\_\_\_\_