DR JOEL BERNSTEIN

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www.sydneyfertility.com.au

Request for the Release of Medical Records/Test Results

I/We 1.___________________________________DOB:___________

2.___________________________________DOB:___________

ADDRESS: ____

____

Request ____

To release my/our medical records and pathology results

TO: Dr. ____

Address:____

____

Phone:______________FAX: ________________eMail_________________

If you wish to have a copy of your records:
Please tick box.

(i) ☐**email address:____**

(note: email not secure)

(ii) ☐**fax address: ____**

I/We understand that due to the Privacy Act (1988), the release of any information requires the signature (s) of each person detailed in the medical record.

Signed 1. ____

Signed 2. ____

Date:________________________________