Request for Copy of Medical Records

I, ________________________________ Date of Birth ___ /___ /______

Would like to request a copy of my medical records, including where available letters, visual field tests and OCT reports from:

Perth Eye Surgeons

Dr Ross Littlewood

Please send my records via:

Email: ____
Email is not a secure method of transmission and there may be security and privacy consequences selecting this option.

Post to: ____

Collection from Midland Eye Clinic
Number to call when records ready to collect: __________________

I am aware of a $40 administration fee for my records to be provided and payment will be required before receiving my records. I wish to pay:

In person at time of record collection

Electronic bank transfer to:
Account name: Eye Services WA • BSB 032-108 • Account #184856
Please include your name as written above as transaction reference

Signed ………………………………………………………....... Date ___ /___ /______

Please return this form together with a **copy of photographic ID** to:
11/56 The Crescent, Midland WA 6056
Fax 08 9374 0623 • Email reception@pertheye.com.au

OFFICE USE ONLY

☐ Payment receipted: / /	Initial:	☐ Called for collection: / /	Initial:
☐ Email verified: / /	Initial:	☐ ID verified/copied: / /	Initial:
☐ Records copied: / /	Initial:	☐ Records sent: / /	Initial: