# Request for the release of AFP Medical Records

Please read the following instructions prior to completing this form.

## What this form is for?

This form is to be used by appointees and ex-appointees of the AFP, or their next of kin, advocate or other third party to request information held on the AFP Medical Records in the custody of AFP SHIELD and the Office of the Chief Medical Officer (OoCMO). All fields must be completed. Incomplete forms will not be actioned.

**Please note:** No information will be provided to anyone other than the appointee or ex-appointee unless legislated to do so or written authorisation has been provided by that person. If that person is deceased, proof of death and proof of relationship must be provided including identity documents.

## Proof of identification of the requester

Identification of the requester must be provided. Acceptable forms of identification include one of the following: an email from the requester’s official AFP email address, a copy of an official identity document which includes a signature or signature and photo, e.g., passport, driver’s licence, pension card, tertiary institution ID card. Do not provide credit card information as a form of identification.

## Proof of relationship

For anyone other than the appointee or ex-appointee, proof of relationship must be established through documents such as: marriage certificate, birth certificate, death certificate, power of attorney or statutory declaration.

## Proof of name change

Where necessary, proof of name change is required to establish proof of identification and/or proof of relationship, e.g., marriage certificate, deed poll, etc.

## Timeframes for completion

Timeframes for the completion of requests for information vary according to the complexity of the task and turnaround may take up to three months. If you have an urgent requirement to access records, please specify this on the request form.

## How will records be provided

By completing this form, the appointee/ex-appointee consents to have their personal medical records copied and sent to themselves or their nominated medical practitioner. AFP SHIELD and the OoCMO reserve the right to send the requested medical records to the general practitioner nominated on the form and not directly to the requester. Records will be sent by mail or email to the address nominated on the form.

## Submission of this form

The preferred method for AFP SHIELD and the OoCMO is to receive this completed form plus identity documents via email to our Health Business Support Team: HealthBST-OoCMO@afp.gov.au.

Alternatively, this completed form and identity documents can be sent via mail to:

AFP SHIELD and the OoCMO
Australian Federal Police
GPO Box 401
Canberra ACT 2601

Please read the instructions prior to completing this form. Note that requests cannot be actioned until identification and proof of relationship have been provided. All fields must be completed. Incomplete forms will not be actioned. To ensure we are providing you with the right information in a timely manner, please be specific about what it is you are seeking.

## Appointee/Ex-appointee details

|  |  |  |
| --- | --- | --- |
| SURNAME: | GIVEN NAMES: | AFP NUMBER: |
| DATE OF BIRTH: / /  | FORMER SURNAMES (if applicable): |
| DATE CEASED EMPLOYMENT (if applicable): / /  | DATE OF DEATH (if applicable): / /  |

### Applicant/Advocate/Third Party details (if not the appointee/ex-appointee)

|  |  |
| --- | --- |
| NAME: | RELATIONSHIP TO THE APPOINTEE/EX-APPOINTEE: |

### Contact details (applicant)

|  |  |
| --- | --- |
| UNIT/NUMBER: |  |
| STREET: |  |
| CITY: |  |
| STATE & POSTCODE: |  |
| E-MAIL ADDRESS: |  |
| TELEPHONE: |  |

### Contact details | Appointee/ex-appointee (if not the applicant)

|  |  |
| --- | --- |
| UNIT/NUMBER: |  |
| STREET: |  |
| CITY: |  |
| STATE & POSTCODE: |  |
| E-MAIL ADDRESS: |  |
| TELEPHONE: |  |

### Records requested (please tick relevant boxes)

|  |  |
| --- | --- |
| [ ]  MEDICAL EXAMINATION RECORDS | [ ]  PATHOLOGY AND TEST RESULTS |
| [ ]  VACCINATION RECORDS(If only requesting this, Medical Practitioner details not required below) |
| [ ]  CLINICAL NOTES REGARDING THE MANAGEMENT OF: | Please specify the specific illness/injury/date(s) of injury or incident(s) |
| NAME OF MEDICAL PRACTITIONER: |  |
| MEDICAL PRACTITIONER CONTACT DETAILS: |  |
| REASON FOR REQUEST:(including reason for urgency) |  |

### Authorisation

|  |  |
| --- | --- |
| APPOINTEE/EX-APPOINTEE SIGNATURE: / / DATE | IF APPLICABLE – PLEASE TICK  I, THE APPOINTEE/EX-APPOINTEE AUTHORISE THE PERSON LISTED ABOVE TO RECEIVE THE RECORDS I AM REQUESTING. |
| APPLICANT/ADVOCATE/THIRD PARTY SIGNATURE: / / DATE |

### AFP SHIELD & Office of the CMO to complete

Date copy released: / /

Emailed Posted Actioned by:

NAME SIGNATURE

For more information, please contact AFP SHIELD and the OoCMO on +61 (0) 2 5127 0111.