FORM A
REQUEST FOR PATIENT TO ACCESS INFORMATION IN
BREAST IMPLANT REGISTRY

TO: Breast Implant Registry
Australian Society of Plastic Surgeons Inc.
Suite 503, Level 5
69 Christie Street
ST LEONARDS NSW 2065

PART A – REQUEST FOR ACCESS (Patient to complete)

I hereby apply for access to information relating to me held on the Breast Implant Registry.

Patient’s Signature: _______________________________________________________
Date:   _______________________________________________________

Please send a copy of my information to:
Address:  _______________________________________________________

_______________________________________________________

A certified copy of proof of identity is supplied as follows
(Please provide at least one of the following. Tick appropriately)

Birth Certificate     □
Passport           □
Certificate of Australian Citizenship □
Medicare Card        □
Driver’s Licence     □
Signed letter from General Practitioner verifying proof □
Other (utility bill, bank statement showing address and name, etc) □
(Please provide details): _______________________________________________
PART B – PATIENT DETAILS (Patient to complete)

Full Name: _______________________________________________________

Address: _______________________________________________________
(At time of surgery)

Date of Birth: _______________________________________________________

Date of Surgery: _______________________________________________________

Name & Address of Surgeon: _______________________________________________________
(At time of surgery)

Optional - Only complete the following if required.

I request that a copy of my document(s) be forwarded directly to my nominated medical practitioner. (Please provide relevant details)

Doctor’s Name: _______________________________________________________

Doctor’s Address: _______________________________________________________

Doctor’s Tel No: _______________________________________________________

Doctor’s Fax No: _______________________________________________________

I hereby give authority for a copy of my document(s) to be forwarded directly to the above doctor:

Patient’s Signature: _______________________________________________________
(Please sign here)

Date: _______________________________________________________

PART C – RECORD OF ACCESS/COLLECTION (For office use only)

Copy of document(s) forwarded to: via Fax / Registered Post / NA

Patient on: _____/_____/_____ □ □ □

Nominated medical practitioner on: _____/_____/_____ □ □ □

Initials: ______