Australian Society of Plastic Surgeons

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):

____

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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) Initials: ______

Copy of document(s) forwarded to:		via	Fax	Registered Post	NA
			(Please tick appropriately)		
Patient on:	______/______/______		☐	☐	☐
Nominated medical practitioner on:	______/______/______		☐	☐	☐