**Please read the following instructions prior to completing this form.**

**What this form is for?**

This form is to be used by members and ex-members 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 the AFP Medical Services. All fields must be completed. Incomplete forms will not be actioned.

**Please note**: No information will be provided to anyone other than the member or ex-member unless 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 member or ex-member, 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 member/ex-member consents to have their personal medical records copied and sent to themselves or their nominated medical practitioner. AFP Medical Services 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 Medical Services is to receive this completed form plus identity documents via email to: Medical-Services@afp.gov.au

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

Medical Services

Australian Federal Police

GPO Box 401

Canberra ACT 2601

**More information**

For more information please contact AFP Medical Services on +61 (0) 2 61315950.

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.

|  |
| --- |
| **Member/Ex-member details** |
| Surname       | Given names       | AFP number       |
| date of birth      /      /      | Former surnames (if applicable)       |
| date ceased employment (if applicable)      /      /           | date of death (if applicable)      /      /      |

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| --- |
| **Applicant/Advocate/Third Party details (if not the member/ex-member)** |
| Name       | Relationship to the member/ex-member       |

|  |  |
| --- | --- |
| **Contact details Applicant** | **Contact Details – Member/Ex-member** (if not the applicant) |
| unit/number |       | unit/number |       |
| street |       | street |       |
| city |       | city |       |
| state & postcode |       | state & postcode |       |
| e-mail address |       | e-mail address |       |
| Telephone |       | Telephone |       |

|  |
| --- |
| **Records requested** *Please tick the relevant boxes* |
| [ ]  medical examination records | [ ]  vaccination records (if only requesting this, Medical Practitioner details not required below) |
| [ ]  pathology and test results | [ ]  clinical notes regarding the management of (please specify the specific illness/ injury/incident)       |
| Name of Medical Practitioner |  |
| Medical Practitioner Contact Details |  |
| Reason for request (including reason for urgency) |  |

|  |
| --- |
| **Authorisation** |
| Member/Ex-member Signature  / / DATE  | (if applicable – please tick)I, the member/ex-member authorise the person listed above to receive the records I am requesting | [ ]   |
| Applicant/Advocate/Third Party Signature  / / DATE  |

**Medical Services to Complete**

Date copy released: \_\_/\_\_/\_\_\_\_

[ ]  Emailed [ ]  Posted Actioned by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 name signature