### **Health Practitioner Reminder Service:**

### **Breast Screen NSW**

**Please COMPLETE and email this form to:** [**data@cancerinstitute.org.au**](mailto:data@cancerinstitute.org.au)

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| **SECTION 1:** Requestor details | | |
| First Name: | Surname: | |
| Professional Status: |  | |
| Practice Name: |  | |
| Healthcare Provider Identifier of the practice (HPI-O): | | |
| Address: | | |
| Suburb: | State: | Post Code: |
| Phone: | Email: | |
| Request Date: | Click here to enter a date. | |

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| **SECTION 2:** Doctor details |
| I would like to request the list of clients that have screened with BreastScreen NSW over the last 24 months. Note: This list will only include clients that have consented to have their results shared with their GP.  All Provider Numbers for which information is requested must be registered with the Practice named above. Please complete a separate Request Form for each Practice. |

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| **DOCTOR’S FIRST NAME** | **DOCTOR’S SURNAME** | **MEDICARE PROVIDER NUMBER** | **HEALTHCARE PROVIDER IDENTIFIER (HPI-I)** |
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| **SECTION 3:** Conditions of release |
| ☐I am requesting this client information on behalf of the doctors listed in section 2, with their knowledge and consent. I agree that the client information will be stored confidentially within the practice. |

Date

Requestors Signature

Data Custodian Signature ☐ Approved Date

**TRIM Reference (Office use only):**