

# ASSISTED REGISTRATION: Application to Register for a My Health Record

## Purpose of this form

This is an application for assisted registration under the *My Health Records Act 2012*. Registration for a My Health Record is voluntary.

You can also register free of charge online at [www.myhealthrecord.gov.au](http://www.myhealthrecord.gov.au), by phoning 1800 723 471, by mail using a different form, or in a Medicare Service Centre.

**Important:** You need to read the Essential Information before you fill out this application.

**Note:** Giving false or misleading information is a serious offence.

## Application for yourself

Please provide the following information about yourself

### 1. Family name

### First given name

2. Gender: M  F

### 3. Date of birth (day, month, year)

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### 4. Please provide **ONE** of the following:

Your Medicare Number

    -       -  **OR**

Your DVA File Number

  -       

### Please read this before answering question 5

**Question 5 is optional.** This information will assist in the planning and provision of appropriate and improved healthcare and services. If you do not answer, your My Health Record will show 'not stated'.

### 5. Are you of Aboriginal or Torres Strait Islander origin?

- No  Yes, Aboriginal  Yes, Torres Strait  
 Yes, both Aboriginal and Torres Strait Islander

### Please read this before answering question 6

Upon the success of your application, we will provide you with an Identity Verification Code (IVC) to access your My Health Record online.

### 6. How do you wish to receive your Identity Verification Code?

By email to:

By SMS to

Through the healthcare provider organisation

7. Please indicate which Medicare information, if any, you would like included in your My Health Record.

Medicare Information	YES	NO
Details of <b>all future claims</b> made for Medicare benefits when you receive a healthcare service that is covered under the Medicare Benefits Schedule (MBS)*	<input type="checkbox"/>	<input type="checkbox"/>
Details of <b>any past claims</b> for Medicare benefits, if available* (This option is only available if you select 'Yes' for 'all future claims' for MBS above)	<input type="checkbox"/>	<input type="checkbox"/>
Details of <b>all future claims</b> made for Pharmaceutical benefits when you receive medication that is covered under the Pharmaceutical Benefits Scheme (PBS)**	<input type="checkbox"/>	<input type="checkbox"/>
Details of <b>any past claims</b> for Pharmaceutical benefits, if available** (This option is only available if you select 'Yes' for 'all future claims' for PBS above)	<input type="checkbox"/>	<input type="checkbox"/>
Your <b>organ and/or tissue donation</b> decision(s), which are sourced from the Australian Organ Donor Register	<input type="checkbox"/>	<input type="checkbox"/>
Details of <b>immunisations</b> , which are sourced from the Australian Childhood Immunisation Register	<input type="checkbox"/>	<input type="checkbox"/>

### Please note:

\* includes claims successfully processed on behalf of the Department of Veterans' Affairs (DVA), in accordance with eligibility entitlements provided by DVA.

\*\* includes claims successfully processed on behalf of DVA under the Repatriation Pharmaceutical Benefits.

**Important:** By completing this form you are consenting to records containing your health information being uploaded to the My Health Record system by registered healthcare provider organisations involved in your care, subject to any express advice you give to your healthcare providers not to upload a particular record, a specified class of records, or any records.

### Applicant's signature

Date   /   /