

# UFS Dispensaries Ltd

## Request for Information



**UFS Dispensaries Ltd**  
Registered Office:  
206 Armstrong St Nth  
BALLARAT VIC 3350

PO Box 301  
BALLARAT VIC 3353  
P: 03 5327 7777  
F: 03 5332 7565

ABN: 490 878 222 59  
E: [members@ufs.com.au](mailto:members@ufs.com.au)

**Under the Privacy Act, UFS Dispensaries may only issue information to the owner of the information or to someone authorised to collect it on their behalf. Information will only be supplied on receipt of an appropriately authorised form.**

Please tick one or more of the following

**\*Medication Information**

Reports contain all items dispensed for the requested period. This report is issued from **individual pharmacies**. Please indicate the period you require and the purpose for which it is required.

From ..... / ..... / ..... to ..... / ..... / .....

- Tax (includes medication and cost only)
- Medication history (includes medication, cost and directions for use)
- Safety Net (PBS item codes and \$ amount only)

**\*Medication information is only available from the pharmacy it was dispensed from. You may ask one pharmacy to collect this information from our other pharmacies on your behalf.**

**Account Records**

This report is only available to customers with an account at UFS Dispensaries. This report contains a record of purchases charged to an account for a period. This report is issued from **Central Office**. Please indicate the period you require.

From ..... / ..... / ..... to ..... / ..... / .....

Acc. No .....

**Purchase History (members only)**

This report contains all purchases under a specific membership for a period of time. **This report will include products that cannot be claimed on tax.** This report is issued from **Central Office**. Please indicate the period you require.

From ..... / ..... / ..... to ..... / ..... / .....

Mem. No .....

I request the information indicated above for myself

First Name	Last Name	Date of Birth	Signature	Member No

The Information indicated above is requested for the following persons who have also signed to give permission for this information to be given to the person listed at the bottom of this form.

First Name	Last Name	Date of Birth	Signature of Record Holder, or Signature of Guardian if Record Holder is under 12 yo	Member No

**Person Requesting/Collecting the Information:**

Name.....  
Address.....  
Suburb..... Postcode..... Phone number.....

Information will generally be available for collection within 24 hours

I consent to the requested information being emailed to the following email address: .....

Signed: ..... Date: .....

