

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION



Health
South Western Sydney
Local Health Network

OFFICE USE ONLY - MRN :

CLIENT/PATIENT DETAILS

Surname (Family Name)..... Title (Mr/s).....
 Given Names..... Date of birth.....
 Residential Address.....
 Postcode.....
 Telephone No. (Home)..... (Work)..... (Mobile).....

APPLICANT DETAILS (IF NOT CLIENT/PATIENT)

Surname (Family Name)..... Title (Mr/s).....
 Given Names..... Date of birth.....
 Residential Address.....
 Postcode.....
 Telephone No. (Home)..... (Work).....
 Relationship of applicant to client/patient.....

- If you are parent/legal guardian, is there a current custody/access order [] No [] Yes. If yes, please attach a copy of the order.
- If you are requesting documents relating to the personal affairs of another person, on their behalf, they must give consent. Note: ID is required from both the patient/client and the applicant.
- In the event that the person is deceased, the applicant must have consent of the executor / administrator of the deceased estate / authorised representative.
- If you are the patient/client's legal guardian a copy of the guardianship order and/or relevant documentation is required.
- Proof of relationship may be required in some circumstances.

CONSENT (if applicable)

I, authorise.....
Client/Patient/Parent/Guardian *Facility/Community Health Centre*

to release a copy of clinical notes relating to..... to.....
Name of Client/Patient *Name of Applicant*

Relationship of applicant to client/patient (if applicable).....

I understand that the information I authorise to be released may be classed as sensitive (according to 15.9 NSW Health Privacy Manual v2 and Section 17 Public Health Act 1991) and may include information related to HIV/AIDS, sexual assault, sexual health, drug & alcohol, aboriginal health, adoption, genetics and organ/tissue donor identification.

Client/Patient Signature: **Date:**

IDENTIFICATION

Two forms of identification (ID) from the list below are required preferably photo ID and at least one with a signature.

Please tick the appropriate box to indicate the identification provided.

- | | | |
|---|---|--|
| <input type="checkbox"/> Medicare Card | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Utility Bills |
| <input type="checkbox"/> Current Drivers Licence (photo) | <input type="checkbox"/> Passport (photo) | <input type="checkbox"/> Tertiary Education ID (photo) |
| <input type="checkbox"/> Pension/Health Care Card | <input type="checkbox"/> Credit/Debit Card | <input type="checkbox"/> Employment ID (photo) |
| <input type="checkbox"/> Certificate of Citizenship | <input type="checkbox"/> Membership card (<i>union or trade, professional bodies, educational institutions</i>) | |
| <input type="checkbox"/> Other - <i>please specify:</i> | | |

BINDING MARGIN - NO WRITING

FILE IN THE CLINICAL RECORD

REORDER: PHOTOCOPY

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DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the NSW Health Department Policy Directive PD2006_050 and Information Bulletin IB2011_038 , the application fee for the information requested is stipulated below.

Please tick the appropriate box to indicate the information/documents you would like to request:

Information Requested	Fees & Conditions (Includes GST)
<input type="checkbox"/> Copy of medical records	\$33.00 up to 80 pages. \$16.50 for holders of Pension/Health Care Card up to 80 pages. Plus photocopying fee of 38.5 cents per page in excess of 80 pages, for holders of Pension/Health Care Card a 50% reduction of the photocopying fee applies.
<input type="checkbox"/> Clinical Imaging / x-ray /photography	Please call for costs.
<input type="checkbox"/> Viewing of medical records	Free
<input type="checkbox"/> Discharge Summary	Free if less than 12 months since attendance. \$33.00 if more than 12 months has lapsed since attendance.
<input type="checkbox"/> Date of Attendance Letter	Free
<input type="checkbox"/> Work Cover Certificate/Medical Certificate	Free if less than one month since attendance. \$33.00 if more than one month has lapsed since attendance.
<input type="checkbox"/> Medical Certificate of Cause of Death	Free if less than 12 months since attendance. \$33.00 if more than 12 months has lapsed since attendance.
<input type="checkbox"/> Medical Report	\$308.00
<input type="checkbox"/> Confirmation of Birth Letter	\$33.00
Mother's Name.....	
Mother's DOB.....	

Date/s or period of attendance for which records are required.....

Describe clearly the documents required

.....

My **Cheque/money order** for \$ _____ fee is enclosed. For fee reduction please supply supporting documents (eg. Pension / Health Care Card). Cheques/money orders should be made payable to **the relevant Clinical Information/ Medical Records Department within the Local Health District** .

Please Note: Cash payment can be made at the facility. Do not send cash through the post.

SIGNATURE.....**DATE**.....

INFORMATION FOR APPLICANTS

- Please try to provide as much detail as you can to help us identify the documents you want.
- We aim to process your request within 21 working days of receipt in the Medical Record Department on the condition that the required information and fees have been received.
- If information contained in the record is deemed to be sensitive, you may be asked to nominate a treating Health Professional who will review the records with you.

FOR FURTHER INFORMATION please contact the relevant Clinical Information / Medical Records Department

PLEASE SEND THIS FORM AND FEE TO: <The relevant Clinical Information Department >

OFFICE USE ONLY

Date Received: Proposed due date:..... Receipt No:.....

MRN:..... Processed By:..... Mode of Delivery: Mail Pick up

ID obtained/sighted: Yes No Date Completed :.....