



Facility: COM GOS LJ WW YYG

APPLICATION FOR ACCESS TO HEALTH RECORDS

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.	
ADDRESS		
		PH
M/C	FIN	
LOCATION / WARD		ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

This form is used to access information under the Health Records and Information Privacy Act 2002. Requests to access information under the Government Information (Public Access) Act 2009 must be referred to the CCLHD Privacy and Right to Information Officer. **This form is filed in the medico-legal section of the medical record.**

Patient/Client Details

Surname (family name) Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Given names

Previous names (if applicable) Date of birth: ___ / ___ / ____

Residential address State Postcode

Phone (H) Work Mobile

Email

Medical record number: (if known)

Applicant Details (If NOT patient/client)

Surname (family name) Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Given names Date of birth: ___ / ___ / ____

Residential address State Postcode

Phone (H) Work Mobile

Email

Relationship of applicant to the patient

If you are parent / legal guardian, is there a current parenting order? ☐ Yes (Please attach a copy of the order) ☐ No

Consent (If applicable)

If you are requesting documents relating to another person, on their behalf, they must give written consent.

Note: Two forms of identification are required from both the patient and the applicant. In the event that the person is deceased, the applicant must have written consent of the person who is the Executor of Will and proof they are the Executor of the Will. If you are the person's legal guardian, a copy of the Guardianship Order / relevant documentation is required.

I,, authorise hospital to release a copy of health records

relating to (patient/client name) to (applicant name)

Relationship to client/patient

I understand that my health record may contain information relating to my medical history and any other conditions not directly related to the purpose for which the information is requested. In particular clinical notes may contain information such as HIV / AIDS (testing, status and result), sexual assault, drug & alcohol, Aboriginal health, adoption, genetics and organ/tissue donor identification or any other information which I, as a patient / client define or interpret as sensitive.

I understand that such information may be released unless I specifically state otherwise. If I have any objections to certain sensitive information being released to the above applicant, I will inform Central Coast Local Health District hospital of my objections in writing.

Patient/Client Signature Date: ___ / ___ / ____

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Details of Request

Please clearly describe documents required:

Are you requesting sensitive information from a: ☐ Sexual Assault/Health record ☐ Mental Health record
☐ Drug & Alcohol record

Date(s) or period of attendance for which records are required:

Method of Access (See below for contact telephone numbers)

☐ I wish to view the documents. (An appointment will need to be made)
☐ I require a copy of the documents

Identification Required

Copies of **two** forms of identification are required, one must be a photo ID. Please tick the appropriate box(es) for documentation provided.

☐ Passport	☐ Certificate of Citizenship	☐ Public Service ID
☐ Utility bills	☐ Employment ID	☐ Drivers Licence
☐ Pension/Centrelink card	☐ Birth Certificate	☐ Medicare Card
☐ Credit/Debit cards	☐ Membership Card (Union or trade, professional bodies, education institution)	
☐ Health Care card	☐ Other (specify)	

Note: If posting documents please ensure copies are certified; a list is available of Australians authorised to certify documents.

Fees, Charges and Payment

Under NSW Health Department Policy the application fee for copies of documents is as follows:

Application fee: \$33 (including GST) for the first 80 pages, \$0.52 (excluding GST) for each additional page, OR
\$16.50 for pensioner/concession card holders for the first 80 pages, \$0.52 (ex GST) for each additional copy (proof required).

Please note: Viewing the file is free.



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Payment details

Credit Card payments can be made on the NSW Payment Portal

Scan the QR Code to access the portal for Central Coast Local Health District

Or navigate to the NSW Health Payment Portal on your internet browser
(<https://paynswhealth.health.nsw.gov.au/other-payments>)

It should display Central Coast Local Health District as the Health Organisation

Click into **Hospital / Facility**, and using the dropdown option, select the facility from those available

Click into **Service**, and using the dropdown option, select Medical Records



Information For Applicants

Please try to provide as much detail as you can to help us identify the documents you require. Your request will be processed by Health Information Services on the proviso that we have the required information, prepaid fee and relevant authority (where applicable).

If information contained in the health record is deemed to be sensitive, it may be required to be reviewed by a clinician before being released.

Access to your health records may be declined in special circumstances, such as where giving access would put you or another person at risk of physical or mental harm.

For copies of documents and further information please contact Health Information Services:

Phone: Gosford (02) 4320 5405

Post to: Health Information Services – Medico-Legal, Gosford Hospital PO Box 361, GOSFORD NSW 2250

Email: CCLHD-HISMedicolegal@health.nsw.gov.au

Office Use Only

MRN

Date received: ___ / ___ / ____ Completion Date: ___ / ___ / ____

Receipt No

Processed by

Mode of Delivery: ☐ Mail ☐ Pick up

Two ID Obtained: ☐ Yes ☐ No