Health
Central Coast
Local Health District

| | |
|---|---|
| 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

**Facility:** COM GOS LJ WW WYG

# APPLICATION FOR ACCESS TO HEALTH RECORDS

COR08438

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

Given names:

Previous name: (if applicable) Date of birth: __ / __ / ____

Residential address:

State: Postcode:

Telephone number home: Work: Mobile:

Email address:

Medical record number: (if known)

## Applicant Details (If NOT patient/client)

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

Given names: Date of birth: __ / __ / ____

Residential address:

State: Postcode:

Telephone number home: Work: Mobile:

Email address:

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.....

## Release of Information

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: __ / __ / ____

## Requesting Notes of Minors

Applications for clinical notes of patients aged < 14 years must have parent/legal guardian consent.

Holes punched as per AS2828 - 2012
BINDING MARGIN – NO WRITING

CATALOGUE NUMBER CC08438-E NOV19/V6

APPLIC. FOR ACCESS TO HEALTH RECORDS

NSW GOVERNMENT

Health
Central Coast
Local Health District

**Facility:** COM GOS LJ WW WYG

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

## 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 ☐ Membership Card (Union or trade, professional bodies, education institution)
☐ Credit/Debit cards ☐ Birth Certificate ☐ Medicare Card
☐ Health Care card ☐ Other (please 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, $0.41 (excluding GST) for each additional page, OR $16.50 for pensioner/concession card holders for the first 80 pages, $0.41 (ex GST) for each additional copy (proof required).

**Please note:** Viewing the file is free.

Please make cheque or money order payable to Gosford Hospital. Please do not send cash in the mail.

## 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

BINDING MARGIN – NO WRITING

Holes punched as per AS2828 - 2012

MARGIN – NO WRITING