REQUEST FOR ACCESS TO INFORMATION

# Patient Details

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

# Applicant Details

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your relationship to the patient?

|  |  |  |
| --- | --- | --- |
| □ I am the patient & the applicant  □ Parent/Guardian |  | □ Spouse or De facto  □ Exercising enduring power of attorney |

# Details of Request

Please tick or outline the specific nature of the information requested:

□ The entire medical record including all admissions, correspondence, investigation results and all other clinical notes

□ Certain sections of the medical record (please detail sections in ‘Other’ below including date range)

□ Progress notes □ Correspondence and Investigation results

□ Operation/Anaesthetic Reports □ Implanted devices/prosthesis

□ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Recipient Details

If the Recipient’s details are different to that of the Applicant please complete recipient details below:

Name of recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode: \_\_\_\_\_\_\_\_\_

Please specify the preferred method of receiving a copy of the requested information:

□ **Email** (Please note it is our usual practice to send a copy of the requested information by secure email) (Please note that if the copy of the requested information is to be collected in person, we will require photographic identification (licence/passport) to validate the identity of the recipient)

□ **Mail** (Please note that it is hospital practice to send the copy of the requested information by registered mail)

□ **Collection by the applicant** (Please note that if the copy of the requested information is to be collected in person, we will require photographic identification (licence/passport) to validate the identity of the recipient)

□ **Collection by the recipient** (Please note that if the copy of the requested information is to be collected in person, we will require photographic identification (licence/passport) to validate the identity of the recipient)

I acknowledge that there may be an administrative charge involved in processing my request and providing access to the requested information. I will be provided with an estimate of the administrative charge which is to be paid in full prior to gaining access to the requested information.

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_