

FOR MEDICAL RECORD USE ONLY
- MEDICAL RECORD COPY -

FACILITY: CALVARY HEALTH CARE SYDNEY

**APPLICATION TO ACCESS PERSONAL
HEALTH INFORMATION**



Health
South Eastern Sydney
Local Health District

CLIENT / PATIENT DETAILS

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

APPLICATION DETAILS (IF NOT CLIENT/PATIENT)

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

- *If the client / patient is under 16 years, parent or guardian authorisation must be obtained.*
- *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*
to release personal health information relating to..... to.....
Name of Client/Patient *Name of Applicant*

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/Parent/Guardian 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"/> Certificate of Citizenship | <input type="checkbox"/> Credit/Debit Card |
| <input type="checkbox"/> Employment ID (photo) | <input type="checkbox"/> Membership card (<i>union or trade, professional bodies, educational institutions</i>) | |
| <input type="checkbox"/> Other - <i>please specify</i> : | | |

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DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the NSW Health Department Policy Directive PD2006_050 and Information Bulletin IB2012_032, 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 and Conditions (includes GST)
<input type="checkbox"/> Copy of medical records (<i>under the Health Records & Information Privacy Act 2002</i>)	\$33.00 up to 80 pages Plus photocopying fee of 38 cents per page in excess of 80 pages.
<input type="checkbox"/> Viewing of medical records	Free
<input type="checkbox"/> Discharge Summary	Free however retrieval costs may apply in some instances.
<input type="checkbox"/> Date of Attendance Letter	Free
<input type="checkbox"/> Medical Report	\$313.50
<input type="checkbox"/> Confirmation of Birth Letter Mother's Name..... Mother's DOB.....	\$33.00

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

Describe clearly the documents required

I require a copy of the documents

To be collected from Medical Records Dept. Name of person collecting

To be posted to

My Cheque/money order for \$ _____ fee is enclosed. Cheques/money orders should be made payable to Calvary Health Care Sydney

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 Records 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 Medical Records Department on 9553 3088

PLEASE SEND THIS FORM AND FEE TO: Medical Records
Calvary Health Care Sydney
PO Box 261 Kogarah NSW 1485

OFFICE USE ONLY

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

MRN:..... Processed By:..... ID Obtained: Yes No

Date Completed :