PATIENT REQUEST TO ACCESS CLINICAL RECORDS

Surname: ____________________

First Name: ____________________

U.R. Number: ____________________

Ward: ____________________ Bed: __________

Please affix patient's identification label

Section 1 – Details of Patient (Patient / Responsible Person to complete)

Name of patient		**Date requested**	/ /

____________________ hereby request a copy of the documents listed at 1 below.
(Name of Patient / Authorised Person)

Basis of authorisation if not the Patient: ____________________

 # Authorised person is a parent of guardian of a minor; a person appointed by power of attorney or advanced Health Directive; another person authorised by law; a person authorised in writing by the patient

Address of Patient and Address of authorised Person (if different)			
		Post code	

Contact Phone Number(s)			
Business hours			
After hours			
Date of birth of Patient		Health Record UR	

1. Please list below the clinical information / documents required

2. Please explain the reason(s) why the documents are required

Provided ID
Certified copy of photographic ID, if you do not have photographic ID, please Contact Privacy Coordinator on (07) 4727

Section 2 – Acknowledgement of potential costs

(Patient / Person Authorised to complete)

I understand that fees are associated with the processing and dispatching of the clinical records in accordance with my request and undertake to pay such fees prior to receiving the copies of the clinical records that I have requested.

I am not aware of any legal or other reason which prevents me from making this request nor any other person or Department that I must consult with before I make this request. There are no court orders in existence which limit my rights to access this information

Name (Please print)			
Signature		Date	

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Section 3 – Approval for Release (OFFICE USE ONLY)

Approval for Release: ❒ Yes ❒ No (If no, please complete section 6)

Name: __________________________ Department: _________________ Signature: ________________________ Date: ___/___/______

Section 4 – Notification to Insurer

Notification to Insurer: ❒ Yes ❒ No

Release of record cleared by insurer: ❒ Yes ❒ No

Section 5 – Applicant Notification

❒ Requested Information available for collection ❒ Requested information withheld Date advised: ___/___/______

❒ Fee advised Amount Due: $_____________ Date : ___/___/______

Contacted by:
Name: _________________________ Position: ______________________ Signature: ______________________ Date : ___/___/______

Section 6 – If Request to Access is Denied (either in whole or in part)

Reasons for Denial / Partial Denial: ____

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____

Name: __________________________ Department: _________________ Signature: ________________________ Date: ___/___/______

Patient / Responsible Person advised of decision and information of appeal process ❒ Yes ❒ No

Name: __________________________ Department: _________________ Signature: ________________________ Date: ___/___/______

Section 7 – Distribution

Forward or post to:
❒ Medical Practitioner ❒ Solicitor ❒ Patient to Collect (Complete below) ❒ Health Fund
❒ Posted to Patient ❒ *Ordinary Mail* ❒ *Registered Mail*
Other (please specify):

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____

Name, address & date when sent: Date: ___/___/______

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Collection by Patient / Responsible Person:
ID sighted, copied and certified ❒ Yes ❒ No
❒ Patient ❒ Responsible Person

SIGNATURE ON COLLECTION

(Please tick type)

❒ Photo ID ❒ Drivers Licence ❒ Passport ❒ Credit Card ❒ Enduring Power of Attorney ❒ Guardianship Order
❒ Other *(please specify)*

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Total Fee $________________	Method of Payment: *(Please circle one)* **Cash Cheque Mastercard Visa EFTPOS Other**

ENSURE THE INFORAMTION REQUEST SPREADSHEET IS UPDATED