FOR MEDICAL RECORD USE ONLY
- MEDICAL RECORD COPY –

FACILITY: Sydney & Sydney Eye Hospital

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

NSW GOVERNMENT 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.

[ ] Medicare Card
[ ] Birth Certificate
[ ] Utility Bills
[ ] Current Drivers Licence (photo)
[ ] Passport (photo)
[ ] Tertiary Education ID (photo)
[ ] Pension/Health Care Card
[ ] Certificate of Citizenship
[ ] Credit/Debit Card
[ ] Employment ID (photo)
[ ] Membership card *(union or trade, professional bodies, educational institutions)*
[ ] Other - *please specify*: ……

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

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APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

Health
South Eastern Sydney Local Health District

DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the NSW Health Department Policy Directive PD2006_050 and Information Bulletin IB2019_036, 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)
[ ] Search fee for copy of medical records (*under the Health Records & Information Privacy Act 2002)*	$33.00 up to 80 pages Plus photocopying fee of 41 cents per page in excess of 80 pages.
[ ] Viewing of medical records	Free
[ ] Discharge Summary	Free however retrieval costs may apply in some instances.
[ ] Date of Attendance Letter	Free

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 **Sydney & Sydney Eye Hospital**.

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 9382 7339

PLEASE SEND THIS FORM AND FEE TO:

Medical Records Department
Sydney & Sydney Eye Hospital
GPO Box 1614, SYDNEY NSW 2001

OFFICE USE ONLY

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

MRN:…… Processed By:…… ID Obtained: [ ] Yes [ ] No

Date Completed :……