APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

FACILITY: Sydney and Sydney Eye Hospital

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

SECTION A: CLIENT / PATIENT DETAILS *Please complete*

Surname (Family Name) …… Title…….
Given Names …….. Date of birth ……..
Residential Address ……
…… Postcode ……..
Telephone No. (Home)…… Work…… Mobile……
Email:……

SECTION B: APPLICANT DETAILS - *Please complete this section if you are applying for access to information of another person*

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.*

SECTION C: 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:** ……

SECTION D: IDENTIFICATION

Two forms of identification (ID) from the list below are required including one with a photo and 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)
[ ] Certificate of Citizenship
[ ] Credit/Debit Card
[ ] Pension/Health Care Card
[ ] Membership card *(union or trade, professional bodies, educational institutions)*
[ ] Employment ID (photo)
[ ] Other - *please specify*: ……

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SECTION E: DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the NSW Health Department Policy Directive PD2006_050 and Information Bulletin IB2018_054, 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)
[ ] Copy of medical records (*under the Health Records & Information Privacy Act 2002)*	$33.00 up to 80 pages $16.50 for holders of Pension/Health Care Card up to 80 pages Plus photocopying fee of $0.52 cents per page in excess of 80 pages. **Our accounts team will email you an invoice for the required amount.** For holders of Pension/Health Care Card, a 50% reduction of the photocopying fee applies
[ ] Viewing of medical records	$33.00 $16.50 for holders of Pension/Health Care Card.
[ ] Clinical Imaging (Xray/CT /MRI/ US)	$15.00 per compact disc (CD).

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 ……

[ ] To be sent via secure email to……

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 28 working days of receipt 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 Health Records Department on on (02) 9382 7339

THIS APPLICATION CAN BE SENT VIA POST TO : Health Records Department
Sydney and Sydney Eye Hospital
GPO Box 1614
Sydney NSW 2001

or VIA EMAIL TO : SESLHD-SSEH-ClinicalInformation@health.nsw.gov.au

OFFICE USE ONLY

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

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

Date Completed :……

July 2026