



**APPLICATION TO ACCESS
PERSONAL HEALTH
INFORMATION**

OFFICE USE ONLY - MRN: _____

CLIENT/PATIENT DETAILS

Surname (Family Name) _____ Title (Mr/s) _____

Given Names _____ Date of birth _____

Residential Address _____

Postcode _____

Telephone No. (Home) _____ (Work) _____ (Mobile) _____

APPLICANT DETAILS (IF NOT CLIENT / PATIENT)

Surname (Family Name) _____ Title (Mr/s) _____

Given Names _____ Date of birth _____

Residential Address _____

Postcode _____

Telephone No. (Home) _____ (Work) _____

Relationship of applicant to client/patient _____

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 or administrator of the deceased estate.*
- *If you are the patient/client's legal guardian or have power of attorney, 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 **Bankstown-Lidcombe Hospital** to release
Client/Patient/Parent/Guardian/Authorised Representative

a copy of clinical notes relating to _____ to _____
Name of Client/Patient Name of Applicant

Relationship of applicant to client/patient (if applicable) _____

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 Public Health Act 2010) 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/Authorised Representative Signature: _____ **Date:** _____

IDENTIFICATION

Two forms of identification 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"/> Credit/Debit Card | <input type="checkbox"/> Employment ID (photo) |
| <input type="checkbox"/> Certificate of Citizenship | <input type="checkbox"/> Membership Card (<i>union or trade, professional bodies, educational institutions</i>) | |
| <input type="checkbox"/> Other - <i>please specify:</i> _____ | <input type="checkbox"/> Digital Card No. _____ | |

BINDING MARGIN - NO WRITING

REORDER: CLINICAL INFORMATION DEPARTMENT - Oct 17/Rev 2.3

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

AMR805.000

DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Fees are charged in line with NSW Ministry of Health Policy Directive PD2006_050 and Information Bulletin IB2019_036

Please tick the appropriate box to indicate the information/documents you would like to request:

| Information Requested | Fees & Conditions (Includes GST) |
|---|---|
| <input type="checkbox"/> Copy of medical records | \$33.00 up to 80 pages \$16.50 for holders of Pension/Health Care Card up to 80 pages Plus photocopying fee of 45 cents per page in excess of 80 pages. For holders of Pension/Health Care Card a 50% reduction of the photocopying fee applies |
| <input type="checkbox"/> Type of Breast Implant Device Inserted <input type="checkbox"/> Viewing medical records | Free |
| <input type="checkbox"/> Discharge Summary | Free if less than 12 months since attendance \$33.00 if more than 12 months has lapsed since attendance |
| <input type="checkbox"/> Date of Attendance Letter | Free |
| <input type="checkbox"/> Work Cover - Certificate of Capacity <input type="checkbox"/> Medical Certificate | Free if less than one month since attendance \$33.00 if more than one month has lapsed since attendance |
| <input type="checkbox"/> Medical Certificate of Cause of Death | Free if less than 12 months since attendance \$33.00 if more than 12 months has lapsed since attendance |
| <input type="checkbox"/> Medical Report | \$361.90 |
| <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 _____

Preferred delivery method (*please circle*): Please post documents OR I will pick up the documents when ready

SIGNATURE _____ **DATE** _____

INFORMATION FOR APPLICANTS

- All identification supplied must be original, if a copy is supplied it must be certified by a Justice of the Peace/Solicitor.
- We aim to process your request within 21 working days from the date all required documents and fees have been received.
- In some circumstances you may be asked to nominate a treating Health Professional to review the records with you.
- For fee reduction supporting documents (eg. Pension / Health Care Card) must be supplied.

Cash or Credit Card Payments can be made in person at the Cashier on Level 2 of the hospital.

Online Payments can be made via the SWSLHD website <https://www.swslhd.health.nsw.gov.au>. Send payment receipt to Email: SWSLHD-Bankstown-Medicolegal@health.nsw.gov.au or Fax: 9722 8308.

PLEASE SEND THIS FORM AND FEE TO: **Clinical Information Department**
Bankstown-Lidcombe Hospital
Locked Bag 1600
Bankstown NSW 2200

Email: SWSLHD-Bankstown-Medicolegal@health.nsw.gov.au
Phone: 9722 8340 or 9722 8338

OFFICE USE ONLY

Date Received: _____ Release Method: Faxed to GP Pick up Mail Other: _____

Date Completed : _____ Processed By: _____