



**APPLICATION FOR ACCESS/RELEASE OF
CLINICAL INFORMATION**

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DOB	M.O	
ADDRESS		
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

PATIENT DETAILS

Title: Mr Mrs Ms Miss Surname (Family Name): _____
 Given Names: _____ Date of Birth: ____/____/____
 Residential Address: _____
 Postcode: _____
 Telephone No. (Home) _____ (Work): _____ (Mobile): _____

IF THIS REQUEST RELATES TO THE RECORDS OF ANOTHER PERSON PLEASE COMPLETE

*If you are requesting documents relating to another person, on their behalf, they must give consent.
 Note: ID is required from both the patient and the applicant. In the event that the person is deceased, the applicant must have consent of the person who is the executor of the will and proof. If you are the person's legal guardian, a copy Of the guardianship order / relevant documentation is required.*

Surname (Family Name): _____ Title: Mr .Mrs Ms .Miss
 Given Names: _____ Date of Birth: ____/____/____
 Residential Address: _____
 State: _____ Postcode: _____
 Telephone No. (Home) : _____ (Work): _____ Mobile: _____
 Relationship of applicant to 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.

CONSENT (if applicable)

I, _____ Authorise _____ Health Service
Client/Patient/Parent/Guardian Health Service
 to release a copy of clinical notes relating to _____ to _____
Name of Client/Patient Name of Applicant
 Relationship to client/patient (if applicable) _____
 Signature: _____ Date: _____

DETAILS OF REQUEST

<input type="checkbox"/>	Copy of Medical Records	<input type="checkbox"/>	Copy of Discharge Summary	<input type="checkbox"/>	Medical Report
<input type="checkbox"/>	Work Cover Certificate	<input type="checkbox"/>	Dates of Attendance	<input type="checkbox"/>	Medical Certificate of Cause of Death
<input type="checkbox"/>	Other				

Date/s or period of attendance for which records are required _____
 Describe Clearly the documents required _____

Please Note: as a matter of routine, information such as medication charts and observation charts are not copied unless they are specifically requested.

BINDING MARGIN NO WRITING

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IDENTIFICATION

ACCEPTABLE FORMS OF IDENTIFICATION: (Two forms of ID are required preferably photo ID, minimum one with a signature)

(Please tick the appropriate box for which documentation has been verified)

- Passport (photo)
- Certificate of Citizenship
- Current driver's licence (photo)
- Birth Certificate
- Public Service ID (photo)
- Membership Card (Union or trade, professional bodies, educational institutions)
- Other – please specify _____
- I have enclosed the require identification

FEES, CHARGES AND PAYMENT

As stipulated under the NSW Ministry of Health Policy Directive PD2006_50 Health Records and Clinical Reports Charging Policy and Information Bulletin IB2018_035 Health Records and Medical/Clinical Reports Rates.

The fee schedule is as follows:

Information Requested	Fee (Includes GST)
Copy of medical records up to 80 pages	\$33.00
- For Holders of pensioner / health care cards	\$16.50
Pages in excess of 80 are charged at	\$0.44 per page
Copy of Discharge Summary	Free if less than 12 months since attendance. \$33.00 if more than 12 months has lapsed since attendance.
Medical Report	\$356.40
WorkCover Certificate/Medical Certificate	
- If less than 1 month since consultation	Free
- If 1 month or more has lapsed since consultation	\$33.00
Dates of Attendance	Free
Viewing fee	Free
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

For Death Certificate—Apply to Registry of Births, Deaths and Marriages

[] My **Cheque/money order** for \$ _____ fee is enclosed. For fee reduction please supply supporting documents. Cheques/money orders should be made payable to HammondCare Health and Hospitals Ltd.

Please Note: Cash payment can be made at the Health Service. 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.
- Your request will be processed by the Clinical Information Service on the proviso that the required information and fees and relevant authority (where applicable) have been received.
- If information contained in the record is deemed to be sensitive, you may be asked to either nominate a treating Health Professional who will review the records with you or to apply for the records under Freedom of Information Act.

For further information please contact the Clinical Information Service

PLEASE SEND COMPLETED FORM AND FEE TO CLINICAL INFORMATION SERVICE OF RELEVANT HOSPITAL

Clinical Information Service Greenwich Hospital PO Box 5084 Greenwich NSW 2065	Clinical Information Service Braeside Hospital 340 Prairie Vale Rd Prairiewood NSW 2176	Clinical Information Service Neringah Hospital 4-12 Neringah Ave South Wahroonga NSW 2076
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OFFICE USE ONLY

MRN: _____ Date Received: _____ Date Completed: _____
 Receipt No _____ Processed By _____ Mode of Delivery: Mail Pickup
 ID Obtained: Yes No View With : _____ Signature of viewing supervisor: : _____