NSW GOVERNMENT **Health**
South Western Sydney
Local Health District

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

CAMDEN & CAMPBELLTOWN HOSPITALS
CLINICAL INFORMATION DEPARTMENT

Ph: 4634 3633 Fax: 4634 3630

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 _____
Client/Patient/Parent/Guardian/Authorised Representative *Hospital/Community Health Centre*

to release 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.

[ ] Medicare Card [ ] Birth Certificate [ ] Utility Bills
[ ] Current Drivers Licence (photo) [ ] Passport (photo) [ ] Tertiary Education ID (photo)
[ ] Pension/Health Care Card [ ] Credit/Debit Card [ ] Employment ID (photo)
[ ] Certificate of Citizenship [ ] Membership Card *(union or trade, professional bodies, educational institutions)*
[ ] Other - *please specify:* _____ [ ] Digital Card No. _____

This form has a reverse side.

REORDER: CLINICAL INFORMATION DEPARTMENT– Jan 20/Rev 2.3

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

AMR805.000

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 & Conditions (Includes GST)
[ ] 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
[ ] Viewing of medical records	Free
[ ] Discharge Summary	Free if less than 12 months since attendance $33.00 if more than 12 months has lapsed since attendance
[ ] Date of Attendance Letter	Free
[ ] Work Cover - Certificate of Capacity [ ] Medical Certificate	Free if less than one month since attendance $33.00 if more than one month has lapsed since attendance
[ ] 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
[ ] Medical Report	$361.90
[ ] 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 _____

_____

[ ] My **Cheque/money order** for $ _____ fee is enclosed. For fee reduction please supply supporting documents (eg. Pension / Health Care Card). Cheques/money orders should be made payable to **South Western Sydney Local Health District.**

Please Note: Cash payment can be made at the facility. Do not send cash through the post.

SIGNATURE _____ **DATE** _____

BINDING MARGIN - NO WRITING

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.
- 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 Clinical Information 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 CLINICAL INFORMATION DEPARTMENT on 4634 3633.

PLEASE SEND THIS FORM AND FEE TO:

CLINICAL INFORMATION DEPARTMENT
CAMPBELLTOWN HOSPITAL
PO BOX 149
CAMPBELLTOWN 2560

OFFICE USE ONLY

Date Received: _____ Proposed due date: _____ Receipt No: _____

MRN: _____ Processed By: _____ Mode of Delivery: [ ] Mail [ ] Pick up

ID Obtained: [ ] Yes [ ] No Date Completed : _____

This form has a reverse side.