



**APPLICATION TO ACCESS  
PERSONAL HEALTH  
INFORMATION**

**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.**

<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. _____	

## DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the NSW Health Department Policy Directive PD2006\_050 and Information Bulletin IB2018\_035, 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)
<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"/> Viewing of 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	Free if less than one month since attendance \$33.00 if more than one month has lapsed since attendance
<input type="checkbox"/> Medical Certificate	
<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	\$362.00
<input type="checkbox"/> Confirmation of Birth Letter	\$33.00
Mother's Name _____	
Mother's DOB _____	

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** \_\_\_\_\_

### 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 UNIT on 9794 1700**

**PLEASE SEND THIS FORM AND FEE TO:      CLINICAL SYSTEMS & INFORMATION MANAGEMENT UNIT  
Fairfield Community Health Centre  
P O Box 215, Villawood NSW 2163**

### 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 : \_\_\_\_\_