



Health
South Western Sydney
Local Health District

FAIRFIELD HOSPITAL
Clinical Information Department
Ph.: 9616 8278 Fax No.: 9616 8281
BH: Mon– Fri (8.00 am to 4.30 pm)

**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 _____
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 Section 15 NSW Health Privacy Manual for Health Information March 2015 and Public Health Act 2010) and may include information related to HIV/AIDS, sexual assault, sexual health, mental 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- Dec 2022/Rev 5

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION AMR805.000

DETAILS OF REQUEST, FEES, CHARGES AND PAYMENT

Under the Ministry of Health 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)
<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 \$16.50 for holders of Pension/Health Care Card
<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 _____

My **Cheque/money order** for \$ _____ fee is enclosed. For fee reduction please supply supporting documents (e.g. 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 Department on 9616 8278

PLEASE SEND THIS FORM AND FEE TO: **Clinical Information Department**
 Fairfield Hospital
 PO Box 5
 Fairfield NSW 1851

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: _____

BINDING MARGIN - NO WRITING