Health
South Western Sydney
Local Health District

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

LIVERPOOL HOSPITAL
Clinical Information Department
Ph: 8738 3751 Fax No.: 8738 3760
BH: 0830-1700 Monday to Friday

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, drug & alcohol, aboriginal health, adoption, genetics and organ/tissue donor identification.

Client/Patient/Authorised Representative Signature: _____ **Date:** _____

IDENTIFICATION

Two forms of certified 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.

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION AMR805.000

BINDING MARGIN - NO WRITING

REORDER: CLINICAL INFORMATION DEPARTMENT– Sept 2019

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)
[ ] 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

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

- 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 8738 3751

PLEASE SEND THIS FORM AND FEE TO:

Clinical Information Department
Liverpool Hospital
Locked Bag 7103
LIVERPOOL BC NSW 1871

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.

BINDING MARGIN - NO WRITING