



**APPLICATION TO ACCESS
PERSONAL HEALTH
INFORMATION**

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.

- | | | |
|---|---|--|
| <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 - 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)
<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	\$361.90
<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 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: _____