APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

NSW GOVERNMENT Health Far West Local Health District

SECTION A: CLIENT/PATIENT DETAILS (Please complete)

Surname (Family Name): _____ Title (Mr/s): _____
Given name(s): _____ Date of Birth: _____
Residential address: _____
_____ Postcode: _____
Telephone No.: Home: _____ Mobile: _____ Email: _____
Client/Patient signature: _____ Date: _____

SECTION B: APPLICANT DETAILS (Please complete this section if you are applying for access to information relating to another person)

Surname (Family Name): _____ Title (Mr/s): _____
Given name(s): _____ Date of Birth: _____
Residential address: _____
_____ Postcode: _____
Telephone No.: Home: _____ Mobile: _____ Email: _____
Relationship to client/patient: _____

1. **Is the client/patient a minor (less than 16 years of age)?** ..... [ ] Yes [ ] No
   If Yes, go to Question 2. If No, go to Question 4.
2. **Are you the client's/patient's parent or guardian?** ..... [ ] Yes [ ] No
   If Yes, go to Question 3. If No, the parent or guardian must complete Section C and provide consent.
3. **Is there a current custody/access order?** ..... [ ] Yes [ ] No
   If Yes, provide a copy of the order. If No, go to Section C.
4. **Is the client/patient deceased?** ..... [ ] Yes [ ] No
   If Yes, go to Question 5. If No, go to Question 6.
5. **Are you the executor of the will or an administrator of the deceased estate?** ..... [ ] Yes [ ] No
   If Yes, provide a copy of the will or Letter of Administration. If No, the executor or administrator must complete Section C and provide consent.
6. **Does the client/patient lack the mental capacity to give consent?** ..... [ ] Yes [ ] No
   If Yes, go to Question 7. If No, the client/patient must complete Section C and provide consent.
7. **Are you the client's/patient's legal guardian or do you have an enduring guardianship?** ..... [ ] Yes [ ] No
   If Yes, provide a copy of the guardianship order and/or relevant documentation. If No, the legal guardian or the person who holds an enduring guardianship must complete Section C and provide consent.

Applicant signature: _____ Date: _____

SECTION C: CONSENT (Please complete this section if you are applying for access to information relating to another person)

I, _____ authorise _____
Client/Patient/Parent/Guardian/Authorised Representative **Facility/Community Health Centre**
to release a copy of clinical notes relating to the client/patient recorded above to _____
Name of Applicant

I understand that the information I authorise to be released may be classed as sensitive (according to Section 15.9 of the NSW Health Privacy Manual for Health Information v3 and Section 17 of the Public Health Act 1991) 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 signature: _____ Date: _____

SECTION D: DETAILS OF REQUEST AND FEES (Please mark the appropriate box below to indicate the information/documents you would like to request)

Information requested	Fees and Conditions (Includes GST) As stipulated under the NSW Ministry of Health Policy Directive PD2006_050 *Health Records and Medical/Clinical Reports-Charging Policy and* Information Bulletin IB2018_035 *Health Records and Medical/Clinical Reports-Rates*)
[ ] 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 $0.45 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 - An appointment will need to be made with Clinical Staff to view the records.
[ ] Discharge Summary	Free – Patients are entitled to a summary upon discharge
[ ] Date of Attendance Letter	Free
[ ] Confirmation of Birth letter Mother's Name: _____ Mother's DOB : _____	Free

[ ] My cheque/money order for $ _____ fee is enclosed. For fee reduction please supply supporting documents (e.g. Pension/Health Care Card).
Cheques/money order should be made payable to **Far West Local Health District**.
Please note: Cash payment can be made at the facility cashier. Do not send cash through the post.

SECTION E: INFORMATION REQUIRED

Date/s or period of attendance for which records are required: _____
Describe clearly the documents required: _____
_____
_____
Indicate facility/facilities the documents are required from: _____

INFORMATION FOR APPLICANTS

- Copies of two forms of identification of the client/patient and applicant (if applicable) is required, preferably photo ID and at least one with a signature.
- We aim to process your request within 21 working days of receipt in the Medico-legal/Release of 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.
- Our practice is to send information via regular Australia Post. If you want to make alternative arrangements please contact the relevant facility to discuss.
- Please clearly indicate on this form if information from multiple facilities within the FWLHD is required.

Please send this form and fees to:

Medico-Legal - Medical Records
Department FWLHD
PO Box 457, Broken Hill NSW 2880

OFFICE USE ONLY

Please tick the appropriate box to indicate the identification provided.
[ ] Medicare Card [ ] Birth Certificate [ ] Tertiary education ID (photo)
[ ] Current Drivers Licence (photo) [ ] Passport (photo) [ ] Pension/Health Care Card
Other – please specify: _____
Date received: _____/_____/_____ Receipt No.: _____ Comments: _____
ID obtained/sighted: [ ] Yes [ ] No Mode of delivery: [ ] Mail [ ] Pick up _____