

APPLICATION FOR ADMINISTRATIVE ACCESS TO HEALTH RECORDS

*For office use only
(Attach Patient ID Label)*

DETAILS OF APPLICANT (Please print)

Full Name	Title (Mr/Mrs/Ms etc)	Surname/ Family Name		
	Given Names		Date of Birth (dd/mm/yy)	
Name used in records (If records requested are under a different name than above, please provide details):				
Postal Address				
	Suburb/Town			Postcode
Tel (Home)	(Work)	(Mobile)	E-Mail	

DETAILS OF APPLICATION

It will help us locate the documents without unnecessary delays if you can provide as many details about the documents as possible, including: in what name they are held (eg. under a maiden name); the hospital or health facility where they are held; the date(s) of treatment to which the application applies.

I REQUEST ACCESS TO THE FOLLOWING DOCUMENTS:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> IN-PATIENT HOSPITAL NOTES | <input type="checkbox"/> OUT-PATIENT NOTES | <input type="checkbox"/> COMMUNITY HEALTH SERVICE NOTES | <input type="checkbox"/> X-RAYS; MRI SCANS, ETC | <input type="checkbox"/> LABORATORY REPORTS |
|--|--|---|---|---|

(Approximate dates of records requested):

RECORDS OF TREATMENT ARISING OUT OF MOTOR VEHICLE ACCIDENT ON _____ (Date)

OTHER (Please specify):

EVIDENCE OF IDENTITY

Before access to personal information can be given, you must provide suitable evidence of your identity. (see over for acceptable forms of documentation)

Evidence of identity documentation accompanies this form.

- YES NO

If you are requesting personal information in respect of another person, the written consent of that person is also required.

A copy of the person's written consent accompanies this form.

- YES NO

PRIVACY NOTICE: Personal information supplied in the course of an application may be used or disclosed in order to deal with the application, and with any review or complaint arising from the application.

SIGNED: _____

DATE: _____

NOTE: DOCUMENTS WILL NORMALLY BE AVAILABLE WITHIN 15 WORKING DAYS AFTER RECEIPT OF COMPLETED APPLICATION AND CONFIRMATION OF IDENTITY/CONSENT. YOU WILL BE NOTIFIED IF THAT DEADLINE CANNOT BE MET.

EVIDENCE OF IDENTITY

To protect patient privacy, satisfactory evidence of identity is required before you can be given access to health information. This can be established by providing one of the following identity documents:

- | | |
|--|---|
| <input type="checkbox"/> Driver's licence
<input type="checkbox"/> Medicare or health benefits card
<input type="checkbox"/> Birth certificate or certified extract from birth register
<input type="checkbox"/> Marriage certificate | <input type="checkbox"/> Identifying page of current passport
<input type="checkbox"/> Naturalisation certificate or citizenship certificate
<input type="checkbox"/> Immigration papers or other documents issued by the Commonwealth Department of Immigration. |
|--|---|

IF APPLYING IN PERSON: Bring an **original** identity document, for sighting/verification by a departmental officer.

IF APPLYING BY MAIL: Send with your application a photocopy of one of the identity documents listed above.

NOTE: The photocopy must bear the **original** signature of a Commissioner for Declarations or a Justice of the Peace (JP), certifying the photocopy to be a true copy of the original document, which they have sighted. Documents that bear a photocopied or facsimile copy of the certification/signature will not be accepted.

DO NOT SEND ORIGINAL IDENTITY DOCUMENTS THROUGH THE MAIL.

FOR OFFICE USE ONLY

Date received			Officer's Signature	
Identity confirmed	<input type="checkbox"/> YES	Officer's Signature	Date	<input type="checkbox"/> NO
Consent verified	<input type="checkbox"/> YES	Officer's Signature	Date	<input type="checkbox"/> NO
← If "NO", application is refused				
PROCESSED UNDER ADMINISTRATIVE ACCESS:				
Release authorised by	Officer's Name	Officer's Signature		Date
Documents released by	Officer's Name	Officer's Signature		Date
Method of release	<input type="checkbox"/> Personal attendance		<input type="checkbox"/> Registered Mail - Acknowledgment of receipt	
	(Applicant's Signature) _____		(Attach receipt) →	
OR				
REFERRED FOR PROCESSING UNDER FOI:				
Referred by	Officer's Name	Officer's Signature		Date
Reason for referral				

This completed form should be placed on the patient's file as a record confirming the details of access granted.