



APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

Request for records from (*please tick*):

- Prince of Wales Hospital
- Royal Hospital for Women
- St. Margaret's Public Hospital (*closed*)
- Crown Street Women's Hospital (*closed*)
- POW/Eastern Sydney Community Health Services
- Prince Henry Hospital (*closed*)
- Queen Victoria Hospital for Women and Babies (*closed*)
- South Sydney Women's Hospital (*closed*)

Note: Limited information may be available from closed facilities

SECTION A: CLIENT/PATIENT DETAILS

Please complete

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

1. Is the client/patient a minor (less than 14 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, sign, date, and go to Section D.
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 or an administrator of the deceased estate? Yes No
If Yes, provide a copy of the will. If No, the executor or administrator must complete Section C and provide consent.
If there is no executor or administrator please state as much in writing with an explanation of your relationship to the patient/client.
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 power of attorney? 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 power of attorney must complete Section C and provide consent.
If there is no legal guardian or a person who holds an enduring power of attorney, please state so in writing with an explanation of your relationship to the patient/client.

Applicant signature: _____ Date: _____

SECTION C: CONSENT

Please complete if you answered 'No' to Questions 2, 5, 6 or Question 7

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: _____

BINDING MARGIN - NO WRITING

FILE IN CLINICAL RECORD

REORDER: MEDICAL RECORDS DEPARTMENT March 15/Rev 2.2

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SECTION D: DETAILS OF REQUEST AND FEES

Please tick the appropriate box below to indicate the information/documents you would like to request

Information requested	Fees and Conditions (Includes GST) <small>(As stipulated under the NSW Ministry of Health Policy Directive PD2006_050 Health Records and Medical/Clinical Reports-Charging Policy and Information Bulletin IB2015_044 Health Records and Medical/Clinical Reports-Rates)</small>
<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 \$0.45 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"/> Clinical imaging / x-ray / photography	\$16.50 per compact disc (CD) \$11.00 per film.
<input type="checkbox"/> Viewing of medical records	\$33 search fee (\$16.50 for holders of Pension/Health Care Card)
<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 / 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"/> Confirmation of Birth letter Mothers name: _____ Mother's DOB: _____	\$33.00

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 **Prince of Wales Hospital**

Please note: Cash and card payment can be made at the facility. Do not send cash or card details through the post.

Date/s or period of attendance for which records are required: _____

Describe clearly the documents required: _____

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 28 working days of receipt in the Medico-legal Department on the condition that the required information and fees have been received. Note: Processing may take additional time due to unforeseen circumstances.
- 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.

For further information please contact the Medico-Legal Section on (02) 9382 3771

Please send this form and fees to: Health Information Unit
Prince of Wales Hospital
Level 0, Dickinson Building
Barker Street
Randwick NSW 2031

OFFICE USE ONLY

Please tick the appropriate box to indicate the identification provided.

- | | | |
|--|--|--|
| <input type="checkbox"/> Medicare Card | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Tertiary education ID (photo) |
| <input type="checkbox"/> Current Drivers Licence (photo) | <input type="checkbox"/> Passport (photo) | <input type="checkbox"/> Pension/Health Care Card |
| <input type="checkbox"/> Other – please specify: _____ | | |

ID obtained/sighted: Yes No Date received: ____/____/____ Receipt No.: _____

ID obtained/sighted by: _____ Mode of delivery: Mail Pick up

BINDING MARGIN - NO WRITING
FILE IN CLINICAL RECORD