Sydney Adventist Hospital

APPLICATION TO ACCESS PERSONAL HEALTH INFORMATION

This form is to be used to access health information under the Privacy Amendment (Enhancing Privacy Protection) Act 2012 (CTH) and Health Records and Information Privacy Act 2002 (NSW).

Health Information Services

185 Fox Valley Road
Wahroonga NSW 2076
Phone: (02) 9480 9390
medicalrecords@sah.org.au

Section 1: Patient details

Surname (Family Name):

_____

Given Name:

_____

Previous Name (if applicable):

_____

Date of Birth:

___ / ___ / _____

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Residential Address:

_____

State: _____ **Postcode:** _____

Email Address:

_____

Telephone: _____ **Date:** ___ / ___ / _____

Patient Signature:

Section 2: Third-party applicant (identification details & criteria)

Instruction: Complete this section only if you are not the patient listed in Section 1.

- **Acting on behalf of patient:** Patient must sign Section 1 "Patient Details" and Section 7 "Patient's Consent".
- **Patient is a minor (<14 years):** a parent / legal guardian must consent. One form of identification must be the birth certificate. If there are any current parenting / court orders, a photocopy of the same is required. If the child is between 14 and 16 years old: their signature is required in Section 1 "Patient Details" and Section 7 "Patient's Consent". (Under Family Law Act 1975)
- **Deceased patient:** Only the Executor(s) of the Will or authorised Administrator of deceased patient's estate can access/consent to access patient's medical record. A photocopy of the page of the Will nominating the Executor(s) or Copy of the administration letter and two forms of identification of Executor(s). A copy of the Death Certificate is required when the patient passed away outside of the hospital.

You are:

☐ Acting on behalf of the patient

☐ Parent / Legal Guardian

☐ Executor of Will

☐ Responsible person

Surname (Family Name):

_____

Given Name:

_____

Previous Name (if applicable):

_____

Date of Birth:

___ / ___ / _____

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Residential Address:

_____

State: _____ **Postcode:** _____

Email Address:

_____

Telephone: _____ **Date:** ___ / ___ / _____

Applicant Signature: _____

Section 3: Patient and applicant identification requirements

Instruction: Provide two forms of identification. One must contain a photograph and signature (e.g., passport or driving license). Specify the documents provided below:

Patient

ID 1: _____

ID 2: _____

Applicant

ID 1: _____

ID 2: _____

Section 4: Patient's consent for release of records

Instruction: This section must be signed by the patient, or the authorised parent guardian.

I understand that my healthcare record may contain information relating to my medical history, and any other conditions not directly related to the purpose for which the information is requested. In particular, clinical notes may contain information such as HIV/AIDS (testing, status and result), sexual assault, drug & alcohol, aboriginal health, adoption, genetics and organ/tissue donor identification or any other information which I as a patient define or interpret as sensitive.

If I have any objections to certain sensitive information being released to the above applicant, I will inform Sydney Adventist Hospital/San Day Surgery Hornsby in writing.

Name of Patient / Parent / Guardian

_____

Patient Signature: _____ **Date:** ___ / ___ / _____

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Section 5: Details of health records being requested/relevant dates or period of attendance

☐ Sydney Adventist Hospital

☐ San Day Surgery Hornsby

Provide details of the information / procedure required:

Section 6: Release of the records

Please select how you would like to obtain the records:

☐ Secure link sent to my email.

☐ Collect a hard copy at HIS Department.

☐ Physical copy sent to residential address.

Section 7: Fee payment

An invoice with exact payment details will be issued once your records have been successfully collated. **Please note that records will only be released upon confirmation of full payment.**

Fees, Charges, and Payment (Amounts include GST)

Fee Type / Description	Amount ($)
Access to clinical notes (up to 80 pages)	$110.00
After the first 80 pages	$0.77 cents per page
Confirmation of birth time (if information is onsite)	$55.00
Confirmation of birth time (if information must be retrieved)	$110.00
Confirmation on attendance & Discharge Summary	Free of charge

- Patients who are pensioner/ concession card holders are entitled to 50% discount over the fees mentioned above (proof required). Full rates will apply for time of birth requests in all cases.
- The above fees apply to all records despite of the form they are being provided.

☐ I **understand and agree** that an invoice will be issued for the administrative/copying costs, and I agree to settle the invoice prior to the release of the records.

Section 8: How to submit your application

Instruction: Please review your application to ensure all required fields are complete, signatures are provided, and the forms of identification are attached.

Submit your completed application using one of the methods below:

- **Via Email (Recommended):** Email your application to: medicalrecords@sah.org.au
- **Via Post:** Mail your physical application to: **Health Information Services (HIS)** Sydney Adventist Hospital, 185 Fox Valley Road, Wahroonga NSW 2076.

Please, do not send this application via fax. Due to privacy regulations and data security standards, faxed copies of health information access applications will not be processed.