Sydney Adventist Hospital

APPLICATION FOR ACCESS TO MEDICAL RECORDS

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). ***Please contact us if you have any questions about access.***

A photocopy, fax or scan of this authorisation is considered as effective and valid as the original.

Medico-Legal Service
Health Information Services
185 Fox Valley Road
Wahroonga NSW 2076
(02) 9480 9386
(02) 9480 9385
medicalrecords@sah.org.au

1. PATIENT DETAILS *(GO TO SECTION 6 IF YOU ARE APPLYING ON BEHALF OF A PATIENT)*

Surname (family name) and /or Previous Name (if applicable): Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:

Given names: Date of Birth: DD / MM / YYYY

Residential address:

State: Postcode:

Telephone number (home): (work): (mobile):

E-mail address:

If you are the patient applying for a copy of your medical record, or you are giving permission for the person in Section 6 to act on your behalf to obtain a copy your medical record, you must still sign here

PATIENT SIGNATURE: Date: DD / MM / YYYY

Please try to provide as much detail as you can to help us identify the information/document/s that you want.

2. DETAILS OF REQUEST

Details of information/document/s required: *(NB: Applications for time of birth must include mother's name and date of birth)*

Date/s of admission/attendance:

3. HOW DO YOU WANT TO ACCESS THE MEDICAL RECORD?

☐ I want the copy of the medical record posted as per the address as above or Page 2 *(the copy is sent by registered post)*
☐ I want to pick up the copy of the medical record *(identification is required to be sighted at the time of pick-up)*
☐ I want the copy of the medical record e-mailed *(only if the paper medical record is able to be scanned–otherwise the copy will be posted)*
☐ **I only want to view the medical record** *(contact the Medico-Legal Service to make an appointment. Identification is required to be sighted/copied at the time of the viewing, there is no fee and up to 10 pages of copying can be done at the time)*

4. IDENTIFICATION REQUIREMENTS

Photocopies of two forms of **patient identification** are required and one **MUST** be a photo ID with signature:

☐ Current driver's licence	☐ Pensioner/Senior's Card	☐ Centrelink Card
☐ Current passport	☐ Medicare Card	☐ Credit/Debit Card
☐ Birth certificate	☐ Health Benefits Card	☐ Proof of Age Card
☐ Employment/Public Service ID	☐ Membership card (e.g. union)	☐ Certificate of Citizenship

5. FEES AND PAYMENT (PRE-PAYMENT IS REQUIRED) *Costs are inclusive of GST.*

• **Administration fee** for copies of the medical record, includes up to 100 pages of photocopying and GST (half price discount with seniors'/student/Centrelink card)	**$77.00** **($38.50)**
• **Excess photocopying fee** for additional pages after the first 100	**70 cents per page** *(NB: GST calculated after pages are counted)*

- **POST** a cheque/money order made out to Sydney Adventist Hospital to the Medico-Legal Service (do not send cash in the mail).
- **DIRECT DEBIT / ELECTRONIC FUNDS TRANSFER (EFT):** **Account Name:** Adventist Healthcare Limited **Account Number:** 240941264 **BSB:** 082057 **Branch:** Sydney **Bank:** NAB. * *Please **PROVIDE** your **REMITTANCE ADVICE** with your application if paying by this method.*

6. IF YOU ARE APPLYING FOR ACCESS TO THE PATIENT'S MEDICAL RECORD AS LISTED ON PAGE 1 SECTION 1, READ THE FOLLOWING AND COMPLETE YOUR DETAILS BELOW

- **The patient wants you to the access their medical record:** the **patient must sign in Section 1 'Patient Details' and below in Section 6.1.** indicating they consent to you accessing or getting a copy of their medical record.
- **The patient is a child <14 years:** a parent / legal guardian must consent and one form of identification must be the birth certificate. If there are any current parenting / custodial orders, a photocopy of same is required. **Where the child is 14 and over, their signature is required in Section 1 'Patient Details' and in Section 6.1.**
- **The patient is deceased:** the Executor/s of the Will is/are the only person/s who can consent to access a medical record. A photocopy of the page of the will nominating the Executor/s is required as well as a copy of the death certificate.
- **The patient is incapacitated / unable to give consent:** a 'responsible person' can consent on the patient's behalf in certain circumstances and photocopies of appropriate documents proving responsibility must be provided, eg. guardianship documents. If there are no such documents, a reason must be given as to why the patient cannot consent and the reason for the request. **Access is not guaranteed.**

IDENTIFICATION REQUIREMENTS: If applying on behalf of the patient as above, as well as documents outlined for each scenario, you must also provide two forms of YOUR identification with the patient's identification per Section 4.

You are ☐ 6.1 Acting on behalf of the patient ☐ 6.2 Parent/Legal Guardian ☐ 6.3 Executor of Will ☐ 6.4 Responsible person

Surname (family name): Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:

Given names: Date of Birth: DD / MM / YYYY

Residential address:

State: Postcode:

Telephone number (home): (work): (mobile):

E-mail address:

If applicable (***responsible person***) – please specify why the patient is unable to consent and your reason for access:

YOUR SIGNATURE: Date: DD / MM / YYYY

FURTHER AUTHORISATION FOR RELEASE OF MEDICAL RECORDS TO A THIRD PARTY

i.e. the applicant consents to a copy of the medical record to go to another person

Tick one IF APPLICABLE otherwise - ☐ **NOT APPLICABLE**

6.1. ☐ I, **THE PATIENT**
6.2. ☐ I, **THE PARENT / LEGAL GUARDIAN**
6.3. ☐ I, **THE EXECUTOR/S OF THE WILL**
6.4. ☐ I, **THE RESPONSIBLE PERSON**

give permission for the copy of the medical record to be released to the person / third party as listed below:

Company / Organisation name (if applicable):

Surname (family name): Given names:

Postal address:

E-mail address:

SIGNATURE: Date: DD / MM / YYYY

6.1. Patient or 6.2. Parent / Guardian or 6.3. Executor/s of the Will or 6.4. Responsible Person

Your request will be processed by the Medico-Legal Service on the proviso that we have received the required information on this form, payment, relevant consent/authority and other documents where applicable. We endeavour to complete your request within 20 working days ***(from the time all requirements have been met).***