RHC104030

BINDING MARGIN - DO NOT WRITE

Ramsay Health Care

Request for Correction of Patient Information

URN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: _____

(Affix Patient ID label here)

APPLICANT DETAILS

1.	Full name of applicant:
2.	Are you requesting correction of your own information or that of someone else? ☐ Own information – ***skip to Q4*** ☐ Someone else – ***continue to Q3***
3.	What is your relationship to the patient?
4.	Primary contact details: Telephone: ..... and/or Email: .....

REQUEST DETAILS

5.	Patient name and medical record number (if known):
6.	Date of Birth:
7.	Reason for requesting amendment of information: ☐ Incomplete ☐ Incorrect ☐ Out of date ☐ Irrelevant ☐ Misleading
8.	Name of the Ramsay Health Care hospital/s that hold the information:
9.	Please specify the information or part(s) of information to be amended:
10.	Please state the reason(s) why you are seeking to amend the information (please attach any supporting documentation):
11.	Please specify the exact amendment(s) to be made (if there is insufficient space on this form, please attach a separate page):

CONDITIONS

a) Patient consent / authority

If you are requesting correction of information about someone else, you must provide either a signed and dated consent form or documentation that validates your authority to make a request on the individual's behalf.

☐ I am requesting to amend to my own record, or I have attached a copy of patient consent / valid authority to this application.

b) Identification

Photo identification is required for both the patient and the applicant if they are different.

☐ I have included a copy of photo identification for both the patient and the applicant (if applicable) with this request.

Signature of Applicant: ..... **Date:** .....

Please return the completed form, along with any supporting documentation, to the appropriate Hospital's Health Information Services department.

REQUEST FOR CORRECTION OF PATIENT INFORMATION

RHC209