RHC103960

BINDING MARGIN - DO NOT WRITE

Ramsay Health Care

Request for Access to Patient Information

URN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: _____

(Affix Patient Identification label here, if available)

APPLICANT DETAILS

1. Full name of applicant: .....

2. Are you requesting access to 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. DOB: .....

7. Reason for requesting access:

8. Specific information requested (please provide as much detail as possible e.g., admission dates, type of medical record such as progress notes or discharge summary, etc):

9. Name of the Ramsay Health Care hospital/s the information is being requested from:

10. Please specify how you would like to access the requested information:

☐ Secure email ☐ Ordinary mail ☐ Collect from Hospital ☐ View at Hospital

11. If you have requested a copy to be sent via secure email or ordinary mail, please provide email address or postal address as applicable below:

REQUEST FOR ACCESS TO PATIENT INFORMATION RHC 208

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CONDITIONS

a) Patient consent / authority to release

If you are requesting information about someone else, you must provide a copy of signed and dated consent with this application. In the event that the patient is deceased, the applicant must have consent of the executor of the will / administrator of the estate. If you are the patient's legal guardian, a certified copy of the relevant guardianship documentation is required. If the patient is under 15 years of age, consent of the patient's guardian or authorised representative must be provided.

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

b) Identification

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

If you have requested for the information to be sent via email or post, please include with this application a copy of photo identification which contains your signature.

If the copy of the requested information is to be collected from or viewed in person at the Hospital, please provide a copy of patient photo ID with this request. The applicant must bring photographic identification on the day so the hospital can validate the identity of the recipient.

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

c) Access fee

An administrative fee may be applied for processing the request and providing access to the requested information. A fee estimate will be provided prior to release of / access to the requested information.

☐ I acknowledge that there may be an administrative fee payable prior to accessing the requested information.

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

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

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