Nathalia District Hospital
Providing Quality Care

Leading our community towards better health

FREEDOM OF INFORMATION
PATIENT/CLIENT INFORMATION ACCESS REQUEST FORM

Patient /Client Details

Patient Surname: Patient Given Name(s):

Previous Name (if applicable): Date of Birth:

Postal Address:

Post Code:

Telephone: Work: Home:

Applicant Details: (if different from the above)

Applicant Surname: Applicant Given Name(s):

Previous Name if applicable): Date of Birth:

Postal Address:

Post Code:

Telephone: Work: Home:

If the patient is a child and a Family Court Order is in place, please provide a copy.

Information required from Medical Record

I wish to access the following (where they exist)(please tick as appropriate)

- □ Acute Medical record
- □ Urgent Care records
- □ Nursing Home record
- □ Community Health including Allied Health, Footcare etc.
- □ Aged Care Assessment Services (ACAS) records
- □ District Nursing Service (DNS) records
- □ Personal Information held by NDH
- □ Other

I wish to have access to information pertaining to the following dates range(s)
(this may be approximate, but cannot be the future)

Please specify the information required (eg whole record, X-ray reports, Pathology results, Outpatient letter only)

Type of Access Requested

I request the following form(s) of access:

- □ View the originals *(at the approval of NDH – appointments are required)*
- □ Obtain copies of the originals *(20 cents per copy unless a current Health Care Card holder)*
- □ Obtain a report summarising contact with NDH *(this option is at the discretion of NDH, and may attract a fee)*
- □ I would like a explanation of the contents of the record

Note: Where information is only held electronically, it will be produced on a DVD.
Where information is held in paper form, it will be produced as a paper copy.

Please complete the following when section if seeking access to a medical record other than our own. The patient must sign the form. Where the patient is deceased, the patient's next of kin must sign the form.

1, ..., of .....
(Patient or Next of Kin) *(Address)*

do hereby authorise Nathalia District Hospital to release information from .....
(Patient's Name)

medical record to the aforementioned applicant.

Signed ..... Date: ...../...../.....
(Patient/Next of Kin Signature)

Return the completed form to:

Director of Nursing
Nathalia District Hospital
36-44 McDonell Street
Nathalia 3638
Fax No. 03 5866 9444

Please Enclose:

Proof of identification *(eg. Photocopy of Drivers licence)*
Application fee of $27.20 or Photocopy of current Health Care/Pensioner Entitlement Card *(where applicable)*

I accept responsibility for payment of the application fee of $27.20, plus an additional charge of 20 cents per page (where I have obtained copies). I note that Nathalia District Hospital has a statutory time frame of 45 days from receipt of this letter, accompanied with the $27.20 fee, to complete this request. I understand that no information will be released until any fees due are paid in full.

Signature Date

NOTE: This form is not required if you would like this information transferred to another medical practitioner or treating team for ongoing care management. This will be transferred directly to the appropriate person upon your consent, without cost. We will automatically release this information to your referring doctors/hospitals, unless you direct us not to, and will also provide them with additional information as they request it, to assist in your ongoing care.

OFFICE USE ONLY
Date Received: □ ID Confirmed □ On Database □ VMIA □ Complete

Staff Signature: Designation: Date: