



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)

- | | |
|--|---|
| <input type="checkbox"/> Acute Medical record | <input type="checkbox"/> Aged Care Assessment Services (ACAS) records |
| <input type="checkbox"/> Urgent Care records | <input type="checkbox"/> District Nursing Service (DNS) records |
| <input type="checkbox"/> Nursing Home record | <input type="checkbox"/> Personal Information held by NDH |
| <input type="checkbox"/> Community Health including Allied Health, Footcare etc. | <input type="checkbox"/> 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.

I, 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 \$28.40 or Photocopy of current Health Care/Pensioner Entitlement Card *(where applicable)*

I accept responsibility for payment of the application fee of \$28.40, 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 \$28.40 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: _____