Canterbury District Health Board
Te Poari Hauora ō Waitaha

Release of Health Information

PATIENT'S DETAILS (RECORDS TO BE ACCESSED)

Full Name of Patient:_____ **NHI:**_____

Other Names known by:_____

Full Residential Address:_____

Date of Birth:_____ Contact Phone:_____

Date Information Required if Urgent: (NOT ASAP) …./……/…….. Reason:_____

Every effort will be made to meet required timeframes, but this will not always be possible. In accordance with the Privacy Act 1993 40 (1), we will respond to your request no later than 20 working days after date of receipt.

REQUESTORS DETAILS

Full Name of Requestor**:**_____

Full Residential Address:_____

Contact Number:_____

INFORMATION REQUESTED

General Medical Record

FROM: CHRISTCHURCH, CHRISTCHURCH WOMEN'S THE PRINCESS MARGARET HOSPITAL, BURWOOD, ASHBURTON & RURAL HEALTH

Date of Injury / medical treatment ……/……/……

☐ Emergency Department

☐ Outpatient Clinic *(Specify)*_____

☐ District Nursing

☐ Admission:

- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Nursing Assessment / Nursing Care Record
- ☐ Referrals
- ☐ Operation Report
- ☐ Monitoring Charts
- ☐ Investigations

☐ Other – Please specify:_____

Medical Imaging:

Date of Injury / medical treatment ……/……/……

☐ Report

☐ Images *(e.g X-Ray, CT, photo)*

☐ Other – please specify:_____

☐ **Mental Health Services**

Dates of attendance:

from ……/……/…… to……/……/……..

Unit(s):_____

(Send requests to: Clinical Records The Princess Margaret Hospital)

Manner in which Information is Requested

☐ Verbal

☐ Photocopy

☐ View Personally

☐ CD *(Medical Imaging only)*

Proof of Identity is required with ALL requests for patient information. If you are a patient authorising another person to act as your agent, proof of your agent's and your own identity is required before Canterbury District Health Board can release information. **Canterbury District Health Board will accept one of the following as proof of identity:-** Drivers Licence or photo/signature page from valid passport OR other form of ID, eg, Community Services Card.

This form and subsequent information are subject to the provisions of the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982. You will receive a reply within 20 working days unless deemed urgent. Further Information is available from the Office of the Privacy Commissioner 0800 803 909 or www.privacy.org.nz

Please complete consent details over page

Authorised by the CDHB Privacy Committee 2010

AUTHORISED CONSENT TO ACCESS HEALTH INFORMATION

Highlighted sections to be completed AND please read Checklist before posting

CONSENT BY INDIVIDUAL TO ACCESS OWN INFORMATION

Signature…… Date……

CONSENT BY CHILD'S LEGAL GUARDIAN TO ACCESS INFORMATION IF UNDER 16 YEARS OF AGE

Name: …… Relationship to Individual: ……

Address: ……Daytime Contact Number: ……

Is there a Counsel for the Child: Yes / No

If Yes Name: ……Contact Number:……

I certify that there are no Protection Orders issued in my name by the Courts restricting access to any of the information held Clinical Record

Signature:……Date:……

CONSENT BY INDIVIDUAL'S ADMINISTRATOR/REPRESENTATIVE TO ACCESS INFORMATION

Individual is deceased and I am the Trustee/executer/administrator of the estate. (COPY ATTACHED)

I hold an enduring Power of Attorney relating to health, copy attached

Name: …… Date: ……

Signature: …… Relationship to Individual: ……

Address: ……Daytime Contact Number: ……

AUTHORISATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

I ……Signature ……

Authorise that access be granted to the below named individual to view / have photocopies / collect the copy of the named individual's clinical record(s) indicated over the page.

Name of person released to:……Relationship……

Address: ……Daytime contact number……

REQUESTOR'S CHECKLIST

- Please ensure you have signed the appropriate section(s) above.
- When signing the appropriate section, ensure that relevant copies of "Enduring Power of Attorney" **or** the Will **or** "Letters of Administration" or Guardianship papers are enclosed

Post completed form with all required attachments to the Hospital you require the information from.
(Address on information sheet)

FOR OFFICE USE ONLY

ID Verified: Yes / No **Form of ID:** Driver's Licence / Passport / Other ID - Specify:……

Request is AUTHORISED Yes / No **Specify reason if No: (OR see attached letter)……**

Date Information Released: ……/……/…… OR if information delivered to applicant in person:

Name and signature of person receiving information:……

Name and signature of staff member processing request:……Date……/……/…..

Canterbury
District Health Board
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Information for requests to view or photocopy Medical Records/ Health Information held at the Canterbury District Health Board.

Please read the following information before completing the authorisation form.

The Canterbury District Health Board is required to safeguard your personal information by ensuring that only you have access to your clinical records, or designated persons names by you. You must therefore personally identify yourself as that person by signing the request form.

If you wish to view your clinical records, you must do so under supervision and must not alter, deface or remove any information. If you believe there are inaccuracies in your information you may seek a correction by writing to the Privacy Officer at the relevant hospital address below.

You may request copies of part or all of your clinical record. However, if your clinical record has been inactive for more than 10 years, it may have been destroyed. We will check first and inform you if this is the case.

Your request may take up to 20 working days to complete. We will inform you if an extension to this timeframe is required.

Canterbury District Health Board may refuse you access or disclosure of certain parts of your clinical record under the provisions of the Health Information Privacy Code 1994. We will state the reason for such a refusal and you do have the right of review of the decision through the Privacy Commissioner.

Clinical Information regarding a deceased person will only be released with the written consent of the executor, or administrator of the deceased estate. If you are the executor or administrator, please provide us with a copy of the documents- this will help us process your request.

Please return the completed form to the hospital you require the information from as below:

Patient Information
Christchurch/Women's Hospital
Private Bag 4710
Christchurch 8140

The Clinical Records Department
The Princess Margaret Hospital
P O Box 800
Christchurch 8140

Clinical Records
Burwood Hospital
Private Bag 4708
Christchurch 8140

Medical Information Officer
Ashburton & Rural Health Services
Private Bag 801
Ashburton 7740

Send requests for Hillmorton, Templeton and Queen Mary Hospitals to:

The Princess Margaret Hospital
Clinical Records Department
P O Box 800
Christchurch 8140

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