

## Hawkesbury District Health Service

Operated by St John of God Health Care and providing  
public patient services under a public-private partnership  
with Nepean Blue Mountains Local Health District.

### Application for Access to Health Care Records

#### DETAILS OF CLIENT WHOSE RECORD IS REQUESTED

Family Name \_\_\_\_\_ Title \_\_\_\_\_

Given names \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Residential address \_\_\_\_\_

Postcode \_\_\_\_\_ Ph. Home: \_\_\_\_\_ Work: \_\_\_\_\_ M: \_\_\_\_\_

#### DETAILS OF THIRD PARTY APPLICANT (if client is not the applicant)

Please tick ✓

- As above, continue to "Details of Request".  
 Request relates to the documents of another person, please complete the following:

Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_ Ph. \_\_\_\_\_ Fax: \_\_\_\_\_ M: \_\_\_\_\_

#### DETAILS OF REQUEST

**Name of Facility to which request is made:** HAWKESBURY DISTRICT HEALTH SERVICE

Dates or period of attendance for which records are required \_\_\_\_\_

Describe clearly the documents required: \_\_\_\_\_

Reason for request: \_\_\_\_\_

#### FORM OF ACCESS

- I wish to view the documents (payment is not required).**  
For VIEWING ONLY of documents, the Medical Record Department will arrange an appointment with you.
- I require a copy of the documents.**  
A copy of all or part of a health care record costs \$33 plus 41 cents per page in excess of 80 pages.  
A 50% fee reduction is available if applicant holds a pension or health care card.

*You will be advised in advance if there are any additional charges. (Please refer to 'Fees and Charges' on the back of this form.)*

#### PAYMENT/COLLECTION METHOD

- I request a 50% reduction in fee and have provided supporting documents to qualify for this**  
(ie: pension card or health care card).
- My cheque / money order/ receipt for the application fee is enclosed.**  
Cheques / Money Order should be made payable to the appropriate Facility. \$33 or \$16.50 (with supporting documents)

**Please indicate how you would like to receive the documents:**

- Please mail to the address above (No responsibility is taken for lost documents)  
 Please notify me when they are ready for collection.

**NOTE:** Do not send cash through the post. Please contact the relevant facility for payment options.

**FULL PAYMENT IS REQUIRED BEFORE DOCUMENTS ARE PROCESSED AND RELEASED**

I, the client hereby request \_\_\_\_\_ to release Medical Records about me to \* myself / the third party applicant. *(insert name of healthcare facility)*

\* Cross out whichever does not apply

Client's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**INFORMATION FOR APPLICANTS (Client and/or Third Party)**

**NOTE: This application is for documents at the nominated facility only.**

Please try to provide as much detail as you can to help us identify the documents you require. Your request will be processed within **21 working days after receipt of fee, identification, and any additional fees (this may include retrieval of records from off-site storage currently \$3.00).**

**Third Party Access**

**NOTE:** If you are requesting another person's health care record, this person must sign this form and provide some identification in addition to the applicant. In the event that the person is deceased, the consent of the Executor of the will can only access the record. Appropriate documents must be produced for the records to be released.

**FEES AND CHARGES**

Under the NSW Health Department Policy Directive 2006\_050 and Information Bulletin IB2010\_041, the charge for providing a copy of the health care record, or part thereof, to a maximum of 80 pages, is \$33. This charge includes search fee, photocopying, labour costs, administrative charges. Records which must be recalled from Archival storage may incur an additional fee.

**Provision of a copy of a health care record in excess of 80 pages will be charged at an additional 41cents per page. (Applicants will be informed of any additional costs and balance must be paid prior to processing and release of the documents).**

**Acceptable forms of identification:** (Please don't send originals in the mail).

Your identification must consist of:

**Either :**  Passport **Or: - 1 from column A and 2 from Column B**

**A**

- Citizen Certificate
- Current driver's licence
- Public Service ID (photo)
- Employment ID (with photo)
- Social Security Card (photo)
- Tertiary Education ID (photo)
- Credit card (photo)

**B**

- Birth Certificate
- Pension Card No: \_\_\_\_\_
- Employment ID (without photo)
- Medicare Card
- Credit/Debit cards, Passbooks
- Utility bills
- Healthcare Card
- Membership card - Educational/Professional bodies

**For further information please contact:**

**Hawkesbury District Health Service** – Health Information Department: Phone: 02 45 60 5579 Fax: 02 45 60 5576

**OFFICE USE ONLY** H.R.N \_\_\_\_\_ Date Received \_\_\_\_\_ Due: \_\_\_\_\_

Fee Paid: \_\_\_\_\_ Receipt No: \_\_\_\_\_ Additional Fee: \_\_\_\_\_ Receipt No: \_\_\_\_\_

Calculation of additional fee: \_\_\_\_\_

ID provided: Yes / No Sighted by: \_\_\_\_\_ Consent from client: Yes / No / Not applicable

View record only: Yes / No Date: \_\_\_\_\_ Supervised by: \_\_\_\_\_

Details of documents provided to applicant: \_\_\_\_\_

Processed by: \_\_\_\_\_ Date Completed: \_\_\_\_\_