FTV200000

mater
private hospital
townsville

# Request to Access Clinical Records

URN: _____

Family Name: _____

Given Name(s): _____

Date of Birth: _____ Sex: ☐ M ☐ F

Please affix patient's identification label

## Section 1- Details of Patient

Name of Patient: _____

Date of Birth: _____ Phone: _____

Email: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

## Section 2 - Details of Authorised* Person

This section is to be completed if the request is made by anyone other than the patient.

***An authorised person is a parent or guardian of a minor; a person appointed by Power of Attorney or Advanced Health Directive; another person authorised by law; a person authorised in writing by patient.**

**Basis of authorisation if not the Patient:** ☐ Parent ☐ Guardian of Minor ☐ Power of Attorney ☐ Advanced Health Directive ☐ Other, specify _____

Name of authorised person: _____

Address of authorised person: _____

Suburb: _____ State: _____ Postcode: _____

Phone: _____ Email: _____

## Section 3 - Details of Documents

I hereby request a copy of the documents listed below:

1. Please list below the clinical information / documents required:

_____

_____

_____

_____

2. Please explain the reason(s) why the documents are required:

_____

_____

## Section 4 - Acknowledgement

I understand that fees are associated with the processing and dispatching of the health records in accordance with my request and I undertake to pay such fees prior to receiving the copies of the clinical records that I have requested. I am not aware of any legal or other reason which prevents me from making this request nor any other person or Department that I must consult with before I make this request. There are no court orders in existence which limit my rights to access this information.

Name: _____

Signature: _____ Date: _____

Request to Access Clinical Records

## Section 5 - Approval for Release (OFFICE USE ONLY)

Approval for Release: ☐ Yes ☐ No (if no, please complete section 6)

Name: _____ Department: _____ Signature: _____ Date: ____/____/____

## Section 6 - Notification to Insurer

Notification to Insurer: ☐ Yes ☐ No

Release of record cleared by insurer: ☐ Yes ☐ No

## Section 7 - Applicant Notification

☐ Requested information available for collection ☐ Requested information withheld Date advised: ___/____/____

☐ Fee advised Amount Due: $_____ Date: ____/____/____

Contacted by:

Name: _____ Position: _____ Signature: _____ Date: ____/____/____

## Section 8 - If Request to Access is Denied (either in whole or in part)

Reason for Denial / Partial Denial: _____

_____

_____

Name: _____ Department: _____ Signature: _____ Date: ____/____/____

Patient / Responsible Person advised of decision and information of appeal process ☐ Yes ☐ No

Name: _____ Department: _____ Signature: _____ Date: ____/____/____

## Section 9 - Distribution

Forward or post to:

☐ Medical Practitioner ☐ Solicitor ☐ Patient to Collect *(Complete below)* ☐ Health Fund ☐ Posted to Patient

☐ *Ordinary Mail* ☐ *Registered Mail*

Other (please specify):

_____

_____

Name, address & date when sent: Date: ____/____/____

_____

_____

Collection by Patient / Responsible Person:

ID sighted, copied and certified: ☐ Yes ☐ No

☐ Patient ☐ Responsible Person

SIGNATURE ON COLLECTION

_____

Total Fee $ _____

Method of Payment: ***(Please tick one)***

☐ Cash ☐ Cheque ☐ Mastercard ☐ Visa ☐ EFTPOS ☐ Other

**ENSURE THE INFORMATION REQUEST SPREADSHEET IS UPDATED**

**Request to Access Clinical Records**

NPS Print Co. - 06/2020