

Clutha Health First is required to safeguard your personal information by ensuring that only you or designated persons named by you have access to your medical records. You must therefore personally identify yourself as that person by signing the attached 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. You may seek a correction of that information by writing to the Privacy Officer at Clutha Health First.

Identification

Identification is necessary to access records. Please supply evidence with your application and/or present ID to Medical Records staff. This could be your driver's licence, passport or community services card.

You will need signed authority and proof of identity to access the medical records of someone else. If you are accessing the records of a child you will need to supply evidence of the relationship you have with that child i.e birth/adoption certificate, or guardianship documents.

Medical information regarding a deceased person will be released **only** with the written consent of the executor or administrator of the deceased estate which is to be provided with the request.

Response Times

We are required to act on requests within 20 working days. If there is going to be a delay in responding to your request we will inform you of this.

Telephone Requests

Anyone requesting information over the telephone will be supplied with a Request to Access Clinical Information Form which needs to be completed and returned.

Copies of Information

Copies are free of charge and you should allow 20 working days for receipt of the information.

You may request copies of part or all of your clinical record. However, if your clinical record has been inactive for more than 10-15 years it may have been destroyed. We will check first and inform you if this is the case.

This request form will be placed in the patients file when the information is viewed, collected or sent.

Refusal to Access

Clutha Health First may refuse you access or disclosure of certain parts of your clinical record under the provision 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.



Access to Clinical Information



**Medical Records Department
Clutha Health First
PO Box 46, 9-11 Charlotte Street
Balclutha**

Telephone (03) 419 0500

Request to Access Clinical Information

Please indicate the type of information you are seeking:

- Access to your Personal Information Access to your Child's Personal Information
 Access to a Deceased Person's Information Granting another Person Access to your Information

Full Name of Patient: _____

Other names known by: _____

Date of birth: _____ NHI: _____

Full Residential Address: _____

Contact telephone number: Day: _____ Mobile: _____

Date the information is required and state reason (if urgent): _____

Manner in which information is requested: Photocopy View personally under supervision

I request to view and / or have copies of medical records for:

Please indicate the service you require information from and if possible the date(s) applicable.

- Inpatient Admission Date(s): _____
 Maternity Record Date(s): _____
 Outpatient Appointments Date(s): _____
 Community (Specify Dept): _____ Date(s): _____
 General Practice Record Date(s): _____

Full Name of Requestor: _____

Full Residential Address: _____

Contact Telephone Number: _____

Consent Process

Personal	I consent to accessing my own information.	Signature: _____ Date: _____
Child	<p>I confirm that I am the Child's parent or legal guardian, who is under 16 years of age, as named above, and I certify that there are no protection orders issued in my name by the Courts restricting access to any of the information held in the medical record.</p> <p>I attach a copy of the child's birth certificate, guardianship or adoption papers (as appropriate) as evidence of my relationship to the child named above.</p> <p>Is there a counsel for the child? <input type="radio"/> No <input type="radio"/> Yes – Indicate below: Counsel name and contact details: _____</p>	Signature: _____ Date: _____
Deceased	The individual is deceased, I am the Trustee/Executor/ Administrator of the Estate (attach copy of evidence)	Signature: _____ Date: _____
Enduring Power of Attorney	I hold and active Enduring Power of Attorney relating to the health and welfare of the individual named above. (attach copy of evidence)	Signature: _____ Date: _____
Disclosure to Third Party ★	<p>I authorise that access be granted to the below named individual to view/have copies/collect the copies of the named individual medical record as indicated above.</p> <p>Name of Person to Release to: _____ Address: _____ Phone No: _____ Relationship: _____</p>	Signature: _____ Date: _____

★ Other health agencies (i.e insurance agencies, ACC etc) may supply evidence of their own written and signed consent form to access the requested information. A copy of this document must be included in the medical record.

Office Only: Request Received: _____ Request: Approved Not Approved: If no state reason: _____
 ID Verified: Yes No Indicate type of ID: _____ Date of Information Release: _____
 Staff Member Processing Request: Name: _____ Signature: _____ Date: _____

On Completion File in Medical Record