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 request a correction page be inserted appropriately into the record.

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.

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.

Parents & Guardians
Parents & Guardians have a limited right of access to their children's information under the age of 16 as per section 22F of the Health Act.

Clutha Health First
Hauora Tahi Ki Iwikatea

Release of Medical Information

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

Telephone (03) 419 0500

For further information:

- www.privacy.org.nz
- Health Information Privacy Code 1994
- Privacy Act 1993
- Official Information Act 1982

Request to Access Clinical Information

Please indicate the type of information you are seeking:

○ Access to your Personal Information
○ Access to your Childs 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: _____
Email Address: _____
Contact telephone number: Day: _____ Mobile: _____
Date the information is required and state reason (if urgent): _____
Manner in which information is requested: ○ Collect ○ View under supervision ○ Email* ○ Post / Courier

*Clutha Health First does not recognise e-mail as always being a secure means of providing information and cannot take any responsibility for information that is accessed or received by others. If, however you would like us to e-mail you the personal health information you have requested, please initial here: _____

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: _____
Signature: _____ **Date:** _____
Full Residential Address: _____
Contact Telephone Number: _____

Consent Process: Complete appropriate section only	
Personal	I consent to accessing my own information. Signature: _____ Date: _____
Child Under 16 years of Age	Full Name: _____ Relationship to Child: _____ Address: _____ Daytime contact number: _____ Is there a counsel for the child: ○ Yes ○ No If yes, Name: _____ Contact No: _____ 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 clinical record.
Consent by Patient Administration/ Representative to Access Information	Patient is deceased and I am the trustee / executor / administrator of the estate (copy attached). I hold an active Enduring Power of Attorney relating to health and welfare (copy attached). Name: _____ Date: _____ Signature: _____ Relationship to Individual: _____ Address: _____ Daytime contact no: _____
Authorisation to Disclose Personal Information to a Third Party	I _____ Signature: _____ Authorise that access be granted to the below named individual to view / have copies / collect the copy of the named individual clinical record(s) as indicated above. Name of Person to Release to: _____ Relationship: _____ Daytime contact no: _____ Address: _____

For Office Use Only: **On completion File in Clinical Record**
Request Received: ..... Request: ○ Approved ○ Not Approved
If not approved, state reason: .....
Form of ID: ○ Drivers Licence ○ Passport ○ Other: ..... ID Verified: ○ Yes ○ No
○ Information released to patient/agent Date of Release: ...../...../.....
Name and Signature of patient or agent receiving information: .....
Processed by staff: (sign) ..... Date: ...../...../.....
File viewing appointment: ..... Date: ...../...../.....

Request to Access Clinical Information Form