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, 3-7 Charlotte Street
Balclutha

Telephone (03) 419 0500

Request to Access Clinical Information

HEALTH FIRST CLUTHA
Hauora Tahi Ki Iwi Katoa

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: ______________________________

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	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. 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. Is there a counsel for the child? ○ No ○ Yes – Indicate below: Counsel name and contact details: ______________	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 ★	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. Name of Person to Release to: ______________ Address: ______________ Phone No: ______________ Relationship: ______________	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

Request to Access Clinical Information Form