



# REQUEST / RELEASE OF PERSONAL / MEDICAL INFORMATION

Patient's Date of Birth		NHI Number:	
Patient's Surname / Family Name: <i>Include Maiden Name</i>		Requestor's Name: <i>If different from Patient</i>	
Patient's Full First Names: <i>Include aliases / other known names</i>		Date Information Required if Urgent (NOT ASAP) <i>Must include reason</i>	
Patient's Contact Details:	<i>Home</i>	<i>Mobile</i>	
Patient's Full Residential Address <i>And</i> Full Postal Address <i>For Mail Delivery</i>		Requestor's Full Residential Address: <i>And</i> Full Postal Address <i>For Mail Delivery</i>	

## INFORMATION REQUESTED

<p style="text-align: center;"><b>General Medical Record</b></p> <p>Date of injury / medical treatment ...../...../.....</p> <p><input type="checkbox"/> Emergency Department</p> <p><input type="checkbox"/> Outpatient Clinic (<i>e.g. Ophthalmology, Cardiology etc includes reports from Doctors, Nurses, referrals from GPs</i>) Specify: _____</p> <p><input type="checkbox"/> District Nursing</p> <p><input type="checkbox"/> Admission</p> <p style="padding-left: 20px;"><input type="checkbox"/> Discharge Summary</p> <p style="padding-left: 20px;"><input type="checkbox"/> Clinical Notes (<i>day to day notes during admission, includes notes from Doctors, Nurses, Physiotherapy, Occupational Therapy, Social Work etc</i>)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Nursing Assessment / Nursing Care Record</p> <p style="padding-left: 20px;"><input type="checkbox"/> Referrals</p> <p style="padding-left: 20px;"><input type="checkbox"/> Operation Report</p> <p style="padding-left: 20px;"><input type="checkbox"/> Monitoring Charts (<i>e.g. Observation Chart, Fluid Balance Chart, Drug Charts, Anaesthesia</i>)</p> <p><input type="checkbox"/> Investigations (<i>test results</i>)</p> <p><input type="checkbox"/> Other – please specify: _____</p>	<p style="text-align: center;"><b>Regional Cancer Treatment Service (RCTS)</b></p> <p>Date of injury / medical treatment ...../...../.....</p> <p><input type="checkbox"/> Outpatient Clinic Reports</p> <p><input type="checkbox"/> Treatment Charts (<i>e.g. Chemotherapy</i>)</p> <p><input type="checkbox"/> Referrals / Correspondence</p> <p><input type="checkbox"/> Investigations (<i>test results</i>)</p> <p><input type="checkbox"/> Other – please specify: _____</p> <hr/> <p style="text-align: center;"><b>Medical Imaging</b></p> <p>Date of injury / medical treatment ...../...../.....</p> <p><input type="checkbox"/> Report</p> <p><input type="checkbox"/> Images (<i>e.g. X-ray, CT, Photo</i>)</p> <p><input type="checkbox"/> Other – please specify: _____</p> <hr/> <p style="text-align: center;"><input type="checkbox"/> <b>Mental Health Services</b></p> <p style="text-align: center;"><i>(Includes Community, Inpatient, Alcohol &amp; Other Drug, Child Adolescent &amp; Family, Intensive Rehabilitation, Early Intervention)</i></p>
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<b>MANNER IN WHICH INFORMATION IS REQUESTED</b>			
<input type="checkbox"/> Verbal	<input type="checkbox"/> Photocopy	<input type="checkbox"/> View Personally	<input type="checkbox"/> CD ( <i>Medical Imaging ONLY</i> )

***This form and subsequent information are subject to the provisions of the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982. You will receive a reply within 20 working days unless deemed urgent.***

**PLEASE COMPLETE DETAILS OVER THE PAGE**

**PLEASE NOTE:**

**Proof of identity is required** with ALL requests for patient information. If you are a patient authorising another person to act as your agent, proof of your agent's and your own identity is required before MidCentral District Health Board can release information. **MidCentral District Health Board will accept one of the following as proof of identity:** - driver's licence OR photo/signature page from valid passport OR other form of ID, eg: Community Services card.

**INDIVIDUAL PATIENT REQUEST FOR COPY OF OWN CLINICAL NOTES**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**Proof of ID is required – attach to this form when returning it.**

**PARENT / GUARDIAN REQUEST FOR COPY OF CHILD(REN'S) CLINICAL NOTES**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Please read statement below\* when signing*  
Relationship to Individual: \_\_\_\_\_  
**\*IMPORTANT:** I certify that there is no Court **Protection Order** issued in my name restricting access to the personal information I am requesting. **Proof of ID is required – attach to this form when returning it.**

**REPRESENTATIVE REQUEST FOR COPY OF PATIENT'S CLINICAL NOTES**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Please read statement below\* when signing*  
Relationship to Individual: \_\_\_\_\_  
**Proof that you are the representative is required. ATTACH** a copy of the Enduring Power of Attorney for personal care and welfare **OR** if the individual is deceased, a copy of the Will or Letters of Administration to this request form. **Proof of ID is required – attach to this form when returning it.**

**PATIENT AUTHORISATION TO DISCLOSE OWN CLINICAL NOTES TO AN AGENT**

I (insert name) \_\_\_\_\_ Signature: \_\_\_\_\_  
authorise release of my notes to: \_\_\_\_\_  
**Proof of ID is required from both patient and agent– attach to this form when returning it.**

**REQUESTOR'S CHECKLIST**

- If you are a patient requesting a copy of your own information, have you - (i) completed and signed the relevant section(s) on this form; and (ii) attached proof of ID?
  - If you are the representative requesting the patient's clinical notes, have you - (i) completed and signed the relevant sections on this form; (ii) attached a copy of the Enduring Power of Attorney OR the Will OR "Letters of Administration"; and (iii) attached proof of your own ID to this form?
  - If you are an agent requesting a copy of a patient's clinical notes, has the patient – (i) completed the 'Patient Authorisation' (see above) section on this form; (ii) provided proof of his/her ID for you to attach and send with this form; and (iii) have you attached proof of your own ID to this form?
  - If you are requesting a deceased patient's clinical notes, have you – (i) obtained authorisation from the deceased person's "representative" for Mid Health Board to release a copy of the clinical notes to you; (ii) attached a copy of the completed/signed authorisation; and (iii) attached proof of your own and the representative's ID to this form?
- Post** completed form with all required attachments to:  
Release of Patient Information Coordinator  
Clinical Quality & Service Improvement  
Midcentral District Health Board  
Private Bag 11036  
PALMERSTON NORTH 4442
- OR E-mail to:**  
[release.patientinfo@midcentraldhb.govt.nz](mailto:release.patientinfo@midcentraldhb.govt.nz)
- OR Deliver** to Clinical Records Department at Palmerston North Hospital

**ID Verified:** Yes / No **Form of ID:** Driver's Licence / Passport / Other ID – specify: \_\_\_\_\_

**OFFICE USE ONLY** **Request is AUTHORISED** Yes / No **Specify Reason if NO: (OR see attached letter)** \_\_\_\_\_

**Date Information Released** .../.../... **OR if information delivered to applicant in person:**

**Name & Signature of person receiving information:** \_\_\_\_\_

**Name & Signature of staff member processing request:** \_\_\_\_\_ **Date:** .../.../...



PERSONAL REPRESENTATIVE AUTHORISATION TO RELEASE A COPY OF A DECEASED PERSON'S INFORMATION

This form MUST be completed by the deceased person's "representative".

Under the Health Information Privacy Code 1994, MidCentral District Health Board cannot release information about a deceased person unless it is being released to, or has been authorised by, the deceased person's "representative".

The term "representative" refers to a "personal representative". This is a legal term referring to the deceased person's executor or administrator.

The representative must authorise MidCentral District Health Board to release a deceased person's information before that can be done. The representative must complete the three parts set out below in this form, i.e., A, B, and C, and provide a copy of the "Will" or "Letters of Administration" as proof that s/he is the deceased person's representative. The representative must also provide proof of his/her own identity i.e., copy of his/her driver's licence OR photo / signature page from his/her passport OR other form of ID e.g.: Community Services card.

The requestor should attach this form together with all other required information and attachments (i.e., proof of your own and the representative's ID) to the "Request / Release of Personal / Medical Information" form when posting or emailing it to MidCentral District Health Board.

Form sections A, B, C, and D with fields for name, address, telephone, and checkboxes for proof of identity.