MidCentral Health

REQUEST FOR RELEASE OF MEDICAL INFORMATION

BARCODE AREA

PART 1 – *please complete relevant section/s*

Patient Details – records to be accessed	
Date of Birth: / /	NHI Number:
Surname/Family Name:	
Full given Names:	
Full Residential Address:	
Home Number:	Mobile Number:

Information Requested

Date of Information required: ___/___/_____ - ___/___/_____ or ☐ Complete Record Required

☐ Emergency Department ☐ Outpatient Clinic: (Please Specify) _____

Allied Health Services

☐ Physiotherapy ☐ Speech Language Therapy ☐ Diet Clinic ☐ Occupational Therapy

☐ Social Work ☐ District Nursing

Admission Information: General Health/Mental Health (Please circle)

☐ Discharge Summary ☐ Clinical Notes ☐ Assessments ☐ Care Plans

☐ Fluid/Food Balance Charts ☐ Medication Charts ☐ Operation Report ☐ Anaesthetic Charts

☐ Observation Charts ☐ Referrals

Investigation Reports:

☐ Haematology ☐ Microbiology ☐ Biochemistry ☐ Serology

☐ Histology ☐ Gastroenterology ☐ ECG ☐ Medical Imaging

Mental Health: *(Please note Mental Health includes Community, Alcohol & Other Drug, Child Adolescent & Family, Oranga Hinengaro, Intensive Rehabilitation and Early Intervention)*

☐ Risk Assessments ☐ Choice/Partnership/Initial Assessments ☐ Psychiatrist/Psychologist

☐ Key Worker Notes ☐ Medication Charts

Please give any specific details about the documentation you are requesting:

_____

MANNER IN WHICH INFORMATION IS REQUESTED

☐ Verbal ☐ Photocopy ☐ View Personally ☐ CD *(Medical Imaging ONLY)*

☐ Email **(to select this option you **must** sign an acknowledgment on the third page)

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.

MCH STAFF USE ONLY		
	Complete upon receipt of request:	**ID Verified**: Yes / No **Form of ID:** Driver Licence / Passport / Other ID – specify: ……
		Verifying Staff Member's Name …….. **Extn** ……
	Complete upon release of information:	**Date Information Released** …./…./…
		Name & Signature of person receiving information: ……
		Name of staff member processing request: …….. **Extn** …….....

BINDING MARGIN – NO WRITING

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 Licence OR photo/signature page from valid passport OR other form of ID, eg: Community Services card.

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PART 2 – *please complete relevant section/s*

A. Request by patient to access own information:

I, _____ (full name), request access to my health information as outlined in Part 1 of this form.

Signature: _____

Date: _____

☐ I have **attached proof of ID** for me as the patient

THIRD PARTY ACCESS REQUESTS

B. Patient's consent and request to release of information to a third party

I, _____ (full name), request and consent to the following person receiving my health information as outlined in Part 1 of this form.

Full name of person (the third party) to receive my health information: _____

Third party's address: _____

Third party's daytime contact phone number: _____

Patient's signature: _____

Date: _____

☐ The third party who is to receive my information has **completed section E** of this form

☐ I have **attached proof of ID** for me as the patient

☐ I have **attached proof of ID** for the third party who is to receive my information

C. Legal guardian's request to access information about a child under 16 years of age

Legal guardian's full name: _____

Relationship to child patient: _____

Address: _____

Daytime Contact Number: _____

Is there a Counsel for the Child?: Yes / No

If yes, Counsel's name: _____ **Contact number:** _____

Legal guardian's signature: _____

Date: _____

Is there a Protection Order issued against you by the Courts relating to this child or anyone involved with this child's care? Yes/No
If yes, please **attach** a copy of the Protection Order for us to assess its impact on your information request.
I request access to the child's health information as outlined in Part 1 of this form.

☐ I have **attached proof of ID** for me as the third party requesting information

☐ I have **attached Birth Certificate**

BINDING MARGIN – NO WRITING

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D. Request by patient's enduring power of attorney/welfare guardian/administrator/executor

☐ *I hold an enduring power of attorney relating to health or have been appointed as welfare guardian for the patient.*

☐ *The individual is deceased and I am the trustee/executor/administrator of his or her estate.*

Name: _____ Date: _____

Address: _____

Daytime Contact Number: _____

I request and consent to the following person receiving the patient's health information as outlined in Part 1 of this form.

Name of person receiving information: _____

Relationship to patient: _____

Address of person receiving information: _____

Signature of patient's representative: _____

☐ I have **attached** a copy of the **Enduring Power of Attorney document/Welfare Guardian Order/Will** OR **Letters of Administration** confirming I am the patient's representative

☐ I have **attached proof of ID** for me as the third party requesting the release of information

☐ I have **attached proof of ID** for the person who will receive the information

BINDING MARGIN – NO WRITING

E. Other third party requests

I wish to receive the patient's health information as outlined in Part 1 of this form and do not fall within any of the previous categories.

Name: _____ Date: _____

Relationship to patient: _____

Reason for request: _____

Address: _____

Daytime Contact Number: _____

Signature: _____

☐ I have **attached proof of ID** as the third party who is to receive information

☐ If the patient has consented to the release of information to me, the patient has **completed section B** of this form and **attached his or her ID.**

**Email can be a powerful communication tool. However, there are very real privacy dangers when sending confidential information via email. It is possible for emails to be accessed or viewed by another internet or computer user without your knowledge or permission.

If you wish to keep your Medical Information strictly private, we advise against consenting to receive it via email.

Declaration: If you are requesting that your information be sent to you or another person by email, you further acknowledge and agree to the risks of transmitting and receiving your information by email and do not hold MidCentral Health liable for any privacy breach which may occur.

Signature of patient: _____ Date: _____

REQUESTOR'S E-MAIL ADDRESS FOR RECEIPT OF MEDICAL INFORMATION

Please provide your e-mail address ONLY if you are happy for MidCentral DHB to use this method to send clinical correspondence to you, instead of via NZ Post. Please advise MidCentral DHB in writing immediately if your contact information changes. Please note: information may be less secure when sent via e-mail. Please sign declaration on back page.

Email Address for Receipt of Clinical Correspondence:

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?; (iii) attached proof of custodial relationship? and (iv) 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 MidCentral District 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
Quality and Clinical Risk
MidCentral District Health Board
Private Bag 11036
PALMERSTON NORTH 4442

☐ **OR E-mail to:**
release.patientinfo@midcentraldhb.govt.nz

☐ **OR Deliver** to Clinical Records Department at Palmerston North Hospital

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