Queensland Government

**MACKAY HOSPITAL & HEALTH SERVICE**

# APPLICATION FOR ADMINISTRATIVE ACCESS TO HEALTH RECORDS

Facility / Unit: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

## DETAILS OF APPLICANT (Please print)

| | | | |
|---|---|---|---|
| Full Name | Title(Mr/Mrs/Ms etc): | Surname/Family Name: | |
| | Given Name: | Date of Birth: _____ / _____ / _____ | |
| | Name used in records (if records requested are under a different name than above, please provide details) | | |
| Postal Address | | | |
| | Suburb/Town | Postcode | |
| Tel (Home) | (Work) | (Mobile) | E-Mail |

## ☐ INFORMATION REQUIRED FOR GP/OTHER HOSPITAL

| | | |
|---|---|---|
| Doctor's/Hospital Name: | Tel: | Fax: |
| Doctors/Hospital Address: | | |

## DETAILS OF REQUEST

It will help us locate the documents without unnecessary delays if you can provide as many details about the documents as possible, including: in what name they are held (eg. Under a maiden name); the hospital or health facility where they are held; the date(s) of treatment to which the application applies.

**I REQUEST ACCESS TO THE FOLLOWING DOCUMENTS:**

| | | | |
|---|---|---|---|
| ☐ IN-PATIENT HOSPITAL NOTES | ☐ OUT-PATIENT NOTES | ☐ COMMUNITY HEALTH SERVICE NOTES | ☐ X-RAYS; MRI SCANS, ETC |
| ☐ LABORATORY REPORTS | ☐ DISCHARGE SUMMARY | ☐ LETTERS | ☐ PROCEDURES |

(Approximate dates of records requested):

_____

| | | | |
|---|---|---|---|
| ☐ COMPLETION OF CERTIFICATE | ☐ WorkCover | ☐ Centrelink | ☐ Medical Certificate |

☐ RECORDS OF TREATMENT ARISING OUT OF MOTOR VEHICLE ACCIDENT ON _____ (Date)

☐ Other (Please specify)

## EVIDENCE OF IDENTITY

| | |
|---|---|
| Before access to personal information can be given, you must provide suitable evidence of your identity (see over for acceptable forms of documentation) | If you are requesting personal information in respect of another person, the written consent of that person is also required. |
| Evidence of identity documentation accompanies this form. | A copy of the person's written consent accompanies this form. |
| ☐ Yes ☐ No | ☐ Yes ☐ No |

**PRIVACY NOTICE:** Personal information supplied in the course of an application may be used or disclosed in order to deal with the application, and with any review or complaint arising from the application.

**SIGNED:** _____ **DATE:** ____/____/_____

**NOTE:** **DOCUMENTS WILL NORMALLY BE AVAILABLE WITHIN 20 WORKING DAYS AFTER RECEIPT OF COMPLETED APPLICATION AND CONFIRMATION OF IDENTITY/CONSENT. YOU WILL BE NOTIFIED IF THAT DEADLINE CANNOT BE MET.**

*Extract from Health Information: Disclosure and access Policy 2005*

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## EVIDENCE OF IDENTITY

To protect patient privacy, satisfactory evidence of identity is required before you can be given access to health information. This can be established by providing one of the following identity documents:

- ☐ Driver's licence
- ☐ Medicare or health benefits card
- ☐ Birth certificate or certified extract from birth register
- ☐ Marriage Certificate
- ☐ Identifying page of current passport
- ☐ Naturalisation certificate or citizenship certificate
- ☐ Immigration papers or other documents issued by the Commonwealth Department of Immigration.

**IF APPLYING IN PERSON:** Bring an **original** identity document, for sighting/verification by a departmental officer.

**IF APPLYING BY MAIL:** Send with your application a photocopy of one of the identity documents listed above. Copies supplied will be securely destroyed once Queensland Health is satisfied as to your identity.

NOTE: The photocopy must bear the **original** signature of a Commissioner for Declarations or a Justice of the Peace (JP), certifying the photocopy to be a true copy of the original document, which they have sighted. Documents that bear a photocopied or facsimile copy of the certification/signature will not be accepted.

**DO NOT SEND ORIGINAL IDENTITY DOCUMENTS THROUGH THE MAIL.**

DO NOT WRITE IN THIS BINDING MARGIN

## FOR OFFICE USE ONLY

| | | | | | |
|---|---|---|---|---|---|
| **Date Received** | | Officer's Signature | | | |
| **Identity confirmed** | ☐ Yes | Officer's Signature | Date | ☐ No | **←If "NO", application is refused** |
| **Type of ID Provided** | | | | | |
| **Consent Verified** | ☐ Yes | Officer's Signature | Date | ☐ No | |

**☐ PROCESSED UNDER ADMINISTRATIVE ACCESS**

| | | | |
|---|---|---|---|
| **Release authorised by** | Officer's Name | Officer's Signature | Date |
| **Documents released by** | Officer's Name | Officer's Signature | Date |
| **Method of release** | ☐ Personal attendance | ☐ Registered Mail – Acknowledgement of receipt | |
| | (Applicant's Signature)_____ | (Attach Receipt)➔ | |

**OR**

**☐ REFERRED FOR PROCESSING UNDER RIGHT TO INFORMATION/INFORMATION PRIVACY ACTS**

| | | | |
|---|---|---|---|
| **Referred by** | Officer's Name | Officer's Signature | Date |
| **Reason for referral** | | | |

**This completed form should be placed on the patient's file as a record confirming the details of access granted.**