



**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:**

<input type="checkbox"/> IN-PATIENT HOSPITAL NOTES	<input type="checkbox"/> OUT-PATIENT NOTES	<input type="checkbox"/> COMMUNITY HEALTH SERVICE NOTES	<input type="checkbox"/> X-RAYS; MRI SCANS, ETC
<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> LETTERS	<input type="checkbox"/> PROCEDURES
(Approximate dates of records requested): _____			
<input type="checkbox"/> COMPLETION OF CERTIFICATE	<input type="checkbox"/> WorkCover	<input type="checkbox"/> Centrelink	<input type="checkbox"/> Medical Certificate
<input type="checkbox"/> RECORDS OF TREATMENT ARISING OUT OF MOTOR VEHICLE ACCIDENT ON _____ (Date)			
<input type="checkbox"/> Other (Please specify) _____			

**EVIDENCE OF IDENTITY**

<p>Before access to personal information can be given, you must provide suitable evidence of your identity (<u>see over for acceptable forms of documentation</u>).</p> <p>Evidence of identity documentation accompanies this form.</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p>If you are requesting personal information in respect of another person, <u>the written consent of that person is also required</u>.</p> <p>A copy of the person's written consent accompanies this form.</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
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**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.**

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying  
All clinical forms creation & amendments must be conducted through Health Information Unit



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Address:

Date of birth:

Sex:  M  F  I

**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.**

**FOR OFFICE USE ONLY**

<b>Date Received</b>		Officer's Signature		
<b>Identity confirmed</b>	<input type="checkbox"/> Yes	Officer's Signature	Date	<input type="checkbox"/> No
<b>Type of ID Provided</b>				<b>← If "NO", application is refused</b>
<b>Consent Verified</b>	<input type="checkbox"/> Yes	Officer's Signature	Date	
<b><input type="checkbox"/> PROCESSED UNDER ADMINISTRATIVE ACCESS</b>				
<b>Release authorised by</b>	Officer's Name	Officer's Signature	Date	
<b>Documents released by</b>	Officer's Name	Officer's Signature	Date	
<b>Method of release</b>	<input type="checkbox"/> Personal attendance		<input type="checkbox"/> Registered Mail – Acknowledgement of receipt	
	(Applicant's Signature) _____	(Attach Receipt) →		
<b>OR</b>				
<b><input type="checkbox"/> REFERRED FOR PROCESSING UNDER RIGHT TO INFORMATION/INFORMATION PRIVACY ACTS</b>				
<b>Referred by</b>	Officer's Name	Officer's Signature	Date	
<b>Reason for referral</b>				

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