Mercy Health
Care first

Mercy Health

UR No:

Family Name:

Given Name:

DOB: Sex:

Address:
(if no UR)

COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL

APPLICATION FOR ACCESS TO CLINICAL RECORDS NSW

FMH052650

Release of information is regulated by the Health Records and Information Privacy Act 2002

DETAILS OF APPLICANT

Title: Family Name: Given Names:

Previous Name (if applicable) : Date of Birth : ____ / ____ / _____

Residential Address (include Postal Address if applicable)

_____

_____

Postcode _____

Tel No. (Home):

Tel No. (Work):

Tel No. (Work):

IF THIS REQUEST RELATES TO THE RECORDS OF ANOTHER PERSON PLEASE COMPLETE

Title: Family Name: Given Names:

Previous Name (if applicable): Date of Birth: ____ / ____ / _____

Residential Address (include Postal Address if applicable)

_____

_____

Postcode _____

Tel No. (Home):

Tel No. (Work):

Tel No. (Work):

Relationship to Applicant*: _____

*If you are the parent/legal guardian, is there a current parenting order? ☐ No ☐ Yes. If yes please attach a copy of the parenting order.

CONSENT OF CLIENT / THIRD PARTY APPLICANT

I, _____ authorise _____ Health

Client/Parent/Guardian/Authorised Representative *Name of Health Service*

Service to release a copy of clinical notes relating to * myself/nominated third party applicant (*cross out whichever does not apply)

Signature: _____ **Date:** _____ / _____ / _____

If you are requesting documents relating to the personal information of another person, on their behalf, they must give consent. Note: ID is required from both the patient and the applicant. In the event that the person is deceased, the applicant must have consent of the authorised representative. Proof of relationship is required. If you are the person's legal guardian a copy of the guardianship order/relevant documentation is required.

Signature or Authorised Representative: _____ **Date:** _____ / _____ / _____

DETAILS OF REQUEST

Date/s or period of attendance for which records are required _____

_____

_____

Describe clearly the documents required _____

_____

_____

PLEASE NOTE: as a matter of routine, information such as medication charts and observation charts are not copied unless they are specifically requested

BINDING MARGIN – NO WRITING

In-house, V1, 02/22

APPLICATION FOR ACCESS TO CLINICAL RECORDS *LEG 0011*

Mercy Health
Care first

APPLICATION FOR ACCESS TO CLINICAL RECORDS NSW

UR No:

Family Name:

Given Name:

DOB: Sex:

Address:
(if no UR)

COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL

FORM OF ACCESS

☐ **I wish to VIEW the documents (No Charge)**
There will be a staff member made available during the viewing session. For VIEWING ONLY of documents, the Health Information
Department will arrange an appointment for you

☐ **I require a COPY of the documents (this may be provided electronically as PDF document)**
A copy of all or part of a clinical record costs $33 (incl GST) plus 41 cents per page in excess of 80 pages. You will be advised prior to processing if there is an excess of 80 pages in your record.

☐ **I wish to DISCUSS patient information relating to a complaint (verbal or written) (No Charge)**
If a person, other than the patient lodges a complaint, any patient information can only be discussed if there is valid consent.

IDENTIFICATION

A current driver's license is acceptable identification otherwise **2 forms of ID** are required preferably one photo ID, and one form of ID must have your signature on it. **Please tick the appropriate box**

☐ Passport (photo)
☐ Certificate of Citizenship
☐ Current driver's licence (photo)
☐ Birth Certificate
☐ Public Service ID (photo)
☐ Centrelink Card
☐ Membership Card (Union or trade, professional bodies, educational institutions)
☐ Other – please specify ……
☐ Employment ID (photo)
☐ Credit/Debit cards
☐ Medicare Card
☐ Utility Bills

☐ **I have enclosed the required identification OR** ☐ **The required identification has been sighted**

FEES, CHARGES AND PAYMENT (no charge for ongoing clinical care or handling of complaints)

The application fee for copies of documents is stipulated under the NSW Health Department Information Bulletin IB2019_036. The charge for providing a copy of a clinical record, or part thereof e.g. progress notes, pathology reports to a maximum of eighty pages is $33 (incl GST). This charge includes search fee, photocopy charges, labour costs, administrative charges and postage. Provision of a copy of a clinical record in excess of 80 pages will be charged at 41 cents per page. The balance must be paid before the documents are released.

☐ Cheque**/money order** for $33 (incl GST) for the copying fee is enclosed. Cheques/money orders should be made payable to Mercy Hospitals NSW Ltd

☐ Direct Debit for $33 (incl GST). Bank details NAB account- BSB 083- 170 Account number 13- 299- 5775

Please note: Cash payment can be made at the Health Service. Do not send cash through the post.

INFORMATION FOR APPLICANTS

- This Facility is authorised to refuse access under the *Health Records & Information Privacy Act 2002 (HPP 7).* This includes information where the release may have an adverse impact on the patient's physical or mental health.
- Please try to provide as much detail as you can to help us identify the documents you want.
- Where a parenting order exists, consideration will be given to the terms of the parenting order prior to information being released.
- Your request will be processed within 21 working days of receipt in the Health Information Department on the provision that the required information and fees have been received.
- If information contained in the record is deemed to be sensitive, you may be asked to nominate a treating Health Professional who will view the record with you.
- This application is for documents at the nominated facility only.

FOR FURTHER INFORMATION please contact the Health Information Department

Mercy Care Centre Young **02 6382 8444**
Mercy Health Albury **02 6042 1400**

PLEASE SEND THIS FORM AND FEE TO:

☐ **Mercy Care Centre Young, PO Box 439, YOUNG NSW 259**
☐ **Mercy Health Albury, PO Box 364, ALBURY NSW 2640**

OFFICE USE ONLY

Date received: ____ / ____ / _____ Due date: ____ / ____ / _____ Receipt no: _____
AUID: _____ ID Obtained: ☐ Yes ☐ No Mode of delivery: ☐ Mail ☐ Pick up
☐ View with: _____ Signature of viewing supervisor: _____
Processed by: _____ Date completed: ____ / ____ / _____

NO WRITING

BINDING MARGIN – NO WRITING