



Queensland Government

Wide Bay Hospital and Health Service

APPLICATION FOR ACCESS TO HEALTH RECORDS

- Hervey Bay Maryborough
- Bundaberg

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

An Application for Access to Health Records will be processed after receipt of the completed application form and confirmation of identity and consent. Applications may be processed under the Health Information: Disclosure and Access Guideline (HIDAG) - Administrative Access, *Right to Information Act 2009* (RTI) or the *Information Privacy Act 2009* (IP). Time frames for completing an application will vary dependent on the process applied to the application.

Documents will normally be available within 20 business days after receipt of a completed application.

DETAILS OF APPLICANT (Please Print)

Title: (Mr/Mrs/Ms etc) Surname/Family Name:

Given Name(s): Date of Birth: (dd/mm/yyyy)
...../...../.....

Name used in records (if records requested are under a different name than above, please provide details):

Postal Address:

Suburb/Town: Postcode

Telephone: (Home) (Work) (Mobile)

DETAILS OF REQUEST

I request access to the following documents

- Discharge Summary only Laboratory / Medical Imaging Reports COVID Pathology Report
- Inpatient Hospital notes Copies of Medical Imaging (e.g. x-rays/scans) \$..... on application
- Outpatient notes **PRICES FOR MEDICAL IMAGING VARY – TO BE NOTIFIED ON APPLICATION**
- Community Health Notes Mental Health (*Please complete RTI/IP form to request*)
- Certificates, Forms / Reports Details: (*Fees may apply*)

It will help us locate the documents without unnecessary delays if you can provide as many details as possible about the documents, including: in what name are they held (e.g. under a Maiden Name); or date(s) of treatment to which the application applies.

- Records of Treatment arising out of Motor Vehicle Accident on/...../.....
- Records of Treatment arising out of Work Cover Accident on/...../.....

Details:

Please note any specific requests below (If you require all records please write ALL):

.....
.....
.....

EVIDENCE OF IDENTITY

Before access to personal information can be given, you will need suitable identity (see over for acceptable forms of documentation).

A copy of the identifying document accompanies this form Yes No

If you are requesting personal information in respect of another person, the written consent of that person is also required.

A copy of the person's written consent accompanies this form Yes No

SIGNATURE: DATE:/...../.....

Transfer method for information: *Please tick* Collection Normal Post Registered Post

Secure email:

00062:HIS01 v6.00 09/2021

Family Name:

Given Name

UR:

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:

- Drivers 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** of one of the above documents for verification and photocopying by departmental officer.

IF APPLYING BY MAIL:

Send with your application a photocopy of one of the identity documents listed above. 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

Copies of identity documents will be securely destroyed once your application has been processed.

OFFICE USE ONLY

Date Received: ____ / ____ / ____	Officer's Signature:
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Identity Confirmed <input type="checkbox"/> Yes <input type="checkbox"/> No	⇐ If NO Application is refused	Officer's Signature:
Consent Verified <input type="checkbox"/> Yes <input type="checkbox"/> No		Officer's Signature:

PROCESSED UNDER: Administrative Access

Release authorised by: Officer's Name and Signature:	Date: ____ / ____ / ____
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Documents released by: Officer's Name and Signature:	Date: ____ / ____ / ____
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Method of release:

Collection Normal Post Registered Post Secure email Fax Other _____

REFERRED FOR PROCESSING UNDER: *Right to Information Act 2009 (RTI)/Information Privacy Act 2009 (IP)*

Referred by: Officer's Name and Signature:	Date: ____ / ____ / ____
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Reason for Referral:

**This completed form is not to be filed in the patient record.
Refer Information Access Unit for processing of application.**