NS GOVERNI
Fac

Hunter New England Local Health District

FAMILY NAME		
GIVEN NAME		

MRN

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 \square FEMALE □ MALE

ility:

CLINICAL INFORMATION SERVICES RELEASE OF INFORMATION REQUEST

INSTRUCTIONS

PART A: FACILITY - Identify the HNE facility where the requested information is available Access http://www.hnehealth.nsw.gov.au for list of all HNELHD facilities, addresses & contact details.

Service Name:

Locked Bag or Street address:

Suburb:

Phone Number:

Email Address:

PART B: APPLICANT DETAILS (Person requesting the information)

Family Name:

Given name/s:

Suburb:

Postal Address (Unit/House/Bldg No.& Street name):

Phone details - Home:

Applicant email:

Signature of Applicant:

☐ I am requesting my own health record (Patient)

Applicant's relationship to the Patient Please provide full details & produce/attach proof of relationship

PART C: PATIENT'S DETAILS (Complete Part C if Patient is not recorded as the APPLICANT in PART B above)

Family Name:

Given name/s:

Postal Address (Unit/House/Bldg No.& Street name):

Suburb:

Phone Details - Home:

Work:

Signature of Patient – required when the patient is over 14 years and has capacity to sign

INSTRUCTIONS: Please read carefully before completing application.

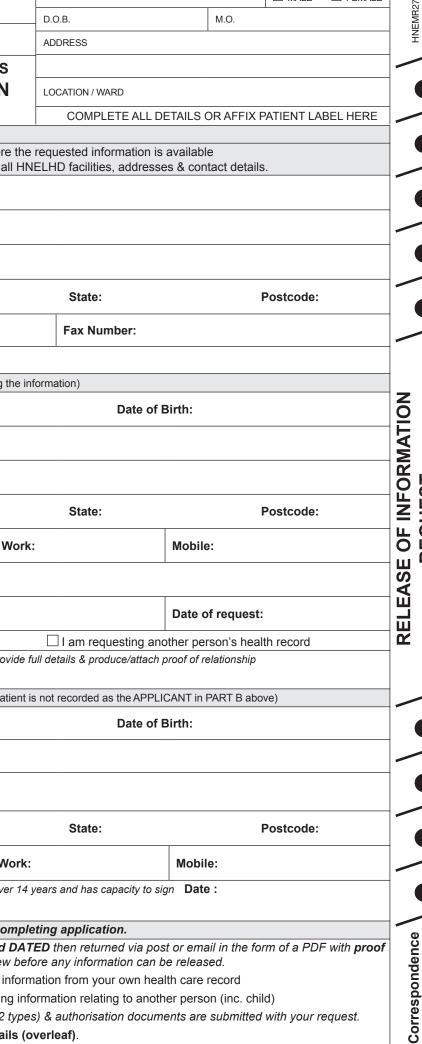
This form must be completed printed, SIGNED and DATED then returned via post or email in the form of a PDF with proof of identity and supporting documentation for review before any information can be released.

Complete: Parts A, B and D if you are requesting information from your own health care record

Parts A, B, C and D if you are requesting information relating to another person (inc. child)

Ensure authenticated copies of identification (min.2 types) & authorisation documents are submitted with your request.

Refer to Part E for Production Fee Payment details (overleaf).



	Hunter New England	FAMILY NAME	FAIVILY NAIVIE	
NSW GOVERNMENT	Local Health District	GIVEN NAME		☐ MALE ☐ FEMALE
Facility	•	D.O.B.	M.O.	
1 acinty	•	ADDRESS		
CLIN	ICAL INFORMATION SERVIC	ES		
REL	EASE OF INFORMATION	ON LOCATION / WARD		
	REQUEST	COMPLETE	ALL DETAILS OR AFFIX P	ATIENT LABEL HERE
PART D : [OOCUMENTS REQUESTED	·		
Admission	/ Attendances date/s:			
From:		To:		
Other Doc	sults (eg Pathology/Imaging)	Discharge Summary/s		
	r Request:			
	roduction method: Photocopy			
Preferred d	lelivery method: Collection	Secure Email	☐ Trackable Post (additio	nal fee may apply)
PART E: P	RODUCTION FEES			
Search and	production fee: \$33.00 (incl. GST) -	(up to 80 pages)		
Upon recei ensure pro- access to the	excess of 80 will incur an additional co or to finalising the request. pt of your completed request to the re- of of patient/guardian identification is the records requested. atton requested will then be research	elevant Clinical Information verified and supporting doc	Department / Service it w cumentation authorises the	ill be reviewed to e applicant to have
payment av	/allable.	OFFICE LISE ONLY		
4 ADDI IOA	TION I TO THE	OFFICE USE ONLY	Descipt No.	
	TION payment confirmed N/A	Yes Amount paid:	Receipt No:	No
	NAL PAYMENT required \(\subseteq \text{N/A} \)			
	excess of 80:			= \$
	reproduction fee (Specify):			\$
Other (S	Specify):			\$
☐ Passpor ☐ Birth Ce ☐ Driver's ☐ Medicard ☐ Healthca	rtificate	sion card (e.g. DVA) Attorney Ship Orders Burt Orders Buse specify):		stice of the Peace (J.P))
	ME:		AFF SIGNATURE:	
	method: Photocopy Electronic		Trackin	ıg number
-	ethod: Collection Secure Ema	ail	Post:	3 114111901
Date comp	leted/sent :			

BINDING MARGIN - DO NOT WRITE