Hunter New England
Local Health District

Facility:

CLINICAL INFORMATION SERVICES
RELEASE OF INFORMATION REQUEST

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B.	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

HNEMR273A

HNE410520

BINDING MARGIN – DO NOT WRITE

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.

Attention:

Service Name:

Locked Bag or Street address:

Suburb: **State:** **Postcode:**

Phone Number: **Fax Number:**

Email Address:

PART B: APPLICANT DETAILS (Person requesting the information)

Family Name: **Date of Birth:**

Given name/s:

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

Suburb: **State:** **Postcode:**

Phone details - Home: **Work:** **Mobile:**

Applicant email:

Signature of Applicant: **Date of request:**

☐ I am requesting my own health record (Patient) ☐ I am requesting another person's health record

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: **Date of Birth:**

Given name/s:

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

Suburb: **State:** **Postcode:**

Phone Details – Home: **Work:** **Mobile:**

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

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)**.

HNEMR273A 220523

RELEASE OF INFORMATION REQUEST

Correspondence

Hunter New England
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B.	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL INFORMATION SERVICES
RELEASE OF INFORMATION REQUEST

PART D : DOCUMENTS REQUESTED

Admission/ Attendances date/s:

From: **To:**

Document Type/s:

☐ Test Results (eg Pathology/Imaging) ☐ Discharge Summary/s

Other Documents required:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Reason for Request: _____

Preferred production method: ☐ Photocopy ☐ Electronic copy

Preferred delivery method: ☐ Collection ☐ Secure Email ☐ Post ☐ Trackable Post *(additional fee may apply)*

PART E: PRODUCTION FEES

Search and production fee: $33.00 (incl. GST) - (up to 80 pages)

Pages in excess of 80 will incur an additional cost of $0.45 per page (incl. $0.041 GST). Any additional costs will be advised prior to finalising the request.

Upon receipt of your completed request to the relevant Clinical Information Department / Service it will be reviewed to ensure proof of patient/guardian identification is verified and supporting documentation authorises the applicant to have access to the records requested.

The information requested will then be researched and the applicant advised of the total cost and the various methods of payment available.

OFFICE USE ONLY

1. APPLICATION payment confirmed ☐ N/A ☐ Yes Amount paid: _____ Receipt No: _____ ☐ No
   MRN: _____

2. ADDITIONAL PAYMENT required ☐ N/A

☐ Pages in excess of 80: _____ @ **$0.451** per page (incl. GST) = $ _____

☐ Imaging reproduction fee *(Specify)*: _____ $ _____

☐ Other *(Specify):* _____ $ _____

TOTAL ADDITIONAL FEE: $ _____

IDENTIFICATION SIGHTED: (Minimum of 2 forms of ID are required – all copies must be certified by Justice of the Peace (J.P))

☐ Passport
☐ Birth Certificate
☐ Driver's License
☐ Medicare Card
☐ Healthcare Card
☐ Other pension card (e.g. DVA)
☐ Power of Attorney
☐ Guardianship Orders
☐ Family Court Orders
☐ Other (please specify) : _____

STAFF NAME: _____ STAFF SIGNATURE: _____

Production method: ☐ Photocopy ☐ Electronic copy

Delivery method: ☐ Collection ☐ Secure Email ☐ Post ☐ Trackable Post: Tracking number

Date completed/sent :

BINDING MARGIN – DO NOT WRITE