HNE410520

BINDING MARGIN – DO NOT WRITE

HNEMR273

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

CLINICAL INFORMATION SERVICES

RELEASE OF INFORMATION REQUEST FORM

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

INSTRUCTIONS

This form must be completed SIGNED, DATED and returned together with production fee and proof of identity before any information can be released.

Complete Part A and Part C if you are requesting information from your own health care record.

Complete Part A, Part B and Part C if you are requesting information on behalf of another person.

Refer to Part D for payment details, include a cheque, money order made out to Hunter New England Local Health District, or complete credit card details at the bottom of Section D (see overleaf) for payment of production fees.

Ensure copies of identification are included with your request.

PART A: APPLICANT / PATIENT'S DETAILS

Surname: _____ DOB: _____ / _____ / _____

Given Names: _____

Postal Address: _____

_____ Postcode: _____

Contact Details: (Home) _____ (Work) _____ (Mobile) _____

SIGNATURE OF APPLICANT: _____ **DATE OF REQUEST:** _____ / _____ / _____

PART B: PATIENT'S DETAILS (if different to the Applicant)

Surname: _____ DOB: _____ / _____ / _____

Given Names: _____

Postal Address: _____

_____ Postcode: _____

Contact Details: (Home) _____ (Work) _____ (Mobile) _____

Applicant's relationship to the patient: _____

(Please give full details and provide proof of that relationship)

SIGNATURE OF PATIENT: _____

(Where the patient is over 14 years of age and able to sign)

DATE OF REQUEST: _____ / _____ / _____

ATTENTION: _____

Service Name: _____

Sector Name: _____

Locked Bag or Street Address: _____

Suburb: _____ State: _____ Postcode: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

180717

RELEASE OF INFORMATION REQUEST FORM

Correspondence

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

CLINICAL INFORMATION SERVICES

RELEASE OF INFORMATION REQUEST FORM

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

PART C: DOCUMENTS REQUESTED

(Please select from the following)

Test Results ☐ Discharge Summary/s ☐

Admission/s Dated: _____ to _____

_____ to _____

_____ to _____

Other Documents:

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

Reason for Request: _____

_____

PART D: PRODUCTION FEES

Search and production fee: $33.00 (incl. $3.00 GST) - (Up to 80 pages). Pages in excess of 80 will incur and additional cost of $0.44 per page (incl. $0.04 GST). Cheques and money orders must be made payable to "Hunter New England Local Health District". See Credit card details below.

OFFICE USE ONLY

PAGES IN EXCESS OF 80: $0.44 per page (incl. $0.04 GST)

TOTAL PAGES: _____

FEE: $_____

IDENTIFICATION SIGHTED:

(A minimum of 2 forms of ID are required)

Passport	☐	Other pension card (e.g. DVA)	☐
Birth Certificate	☐	Power of Attorney	☐
Drivers License	☐	Guardianship orders	☐
Medicare Card	☐	Family Court orders	☐
Healthcare Card	☐	Other (please specify)	☐ _____

STAFF SIGNATURE: _____

DATE INFORMATION SENT: _____ / _____ / _____

Express Post ☐

CREDIT CARD

Type of Card: Mastercard ☐ Visa ☐ Amex ☐

Name on Card: _____

Contact number for Card Holder: _____

Card No.: _____ **Expiry Date:** ____ / ____

Signature: _____ **Amount: $**_____

CREDIT CARD DETAILS MUST NOT BE FILED OR SCANNED INTO THE HEALTH RECORD

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180717