Bethesda health care

APPLICATION FOR ACCESS TO INFORMATION

RETURN TO: Health Information Manger
PO Box 45
CLAREMONT
WESTERN AUSTRALIA 6910
Ph: 9340 6300

APPLICANT DETAILS

Mr/Mrs/Miss/Ms/Dr: ..... Surname: ..... Given Names: .....

Date of Birth: ..... Telephone No.: [H] ..... [M] .....

Australian Postal Address: .....

..... State: ..... Postcode: .....

Email: .....

Applicants relationship to Patient: Self / Next of kin / Other .....

Signed written consent must be obtained from patient to obtain medical records on behalf of the patient.

If the patient is deceased, certified consent for the executor of the Will or Administrator of the Estate must be provided

PATIENT DETAILS ☐ TICK IF SAME AS ABOVE

Surname: ..... Given Names: ..... Date of Birth: .....

DETAILS OF REQUEST

Describe clearly the documents you wish to access (including date, location, subject matter or any other information which would help identify the documents/information requested)

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REASON FOR REQUEST

Please outline the reason you wish to access the documents/information

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DISTRIBUTION (PLEASE CIRCLE A DELIVERY METHOD)

Requested information to be **COLLECTED** in person
(Certified identification will be required prior to release of information)

OR

Requested information to be **POSTED** by registered mail
(Certified identification will be required prior to release of information)

OR

Other

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(Please specify)

** Proof of Identification is required to collect requested information in person*

FEES AND CHARGES

I acknowledge that I may be charged an administration fee for the processing of my application which includes retrieval of information, photocopying, postage and delivery. An invoice will be provided which is to be paid prior to the requested information being released.

Applicants Signature: ..... Date: ...../...../.....

This application may take up to 30 days to process as per legislation.

A certified original copy of identification (e.g. photocopy of passport or drivers' licence) must accompany the application form, for the application to be processed.
Electronic signatures are not accepted, handwritten signature only

(Hospital use only)

MRN: ..... Received on: ...../...../..... Acknowledgment sent on: ...../...../.....

Approval for release: ☐ Yes ☐ No Information dispatched Date: ...../...../.....

Reasons for Denial / Partial Denial: .....

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Requestor notified of Denial: ☐ Yes Date: ...../...../.....

Name of Officer: ..... Position: ..... Signature: .....