



Appendix 7.2

Bethesda
Hospital

Application to AMEND Patient Information

RETURN TO: Health information Manager

PO Box 45

CLAREMONT

WESTERN AUSTRALIA 6910 Ph: 9340 6300

SECTION 1: Applicant Details

Name of Patient:

Date:

Requested:

Name of Applicant:

(If not patient, tick below relationship to patient, ie. Guardian, Parent, Power of Attorney etc)

Parent

Spouse or Defacto

Child or Sibling > 18 years

Relative > 18 years and member
of patients household

Guardian

Enduring Power of Attorney

Intimate personal relationship with patient

Person nominated by patient to be contacted
in case of emergency

Address:

Post Code:

Contact Phone Number(s):

Business Hours:

After Hours:

Date of Birth:

Medical Record No:

Admission No:

Signature:

Date: / /

SECTION 2: Amendment Details

Please specify the exact amendment and reasons for the amendment that you wish to have noted on the hospital patient record

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

Signature:

Date: / /



Appendix 7.2

Bethesda Hospital

Application to AMEND Patient Information

RETURN TO: Health information Manager

PO Box 45

CLAREMONT

WESTERN AUSTRALIA 6910 Ph: 9340 6300

SECTION 3: Amendment Denied - Details:

If request to amend the record is denied, please state reasons for denial:

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

Name (please print)

Signature:

Date: / /

Requestor notified of decision and reasons

YES

NO

Name (please print)

Signature:

Date: / /

SECTION 4: Hospital Verification

BETHESDA Private Hospital undertakes to ensure that this amendment will be filed with the Hospital Patient Records.

Verification of Patient or Authorised Person Identity:

YES

NO

I.D sighted, copied and certified

(Please Tick type)

Photo ID

Drivers licence

Credit card

Guardianship order

Enduring power of attorney

Other (please specify)

Passport

Signed on behalf of

.....
Name and Position:

.....
Department:

.....
Signature: