South Perth Hospital

REQUEST TO AMEND

PATIENT INFORMATION

Your right of amendment. Under the Privacy Amendment (Enhancing Privacy Protection) Act 2012, you generally have the right to request an amendment to the personal information that we hold about you. This includes information that we store electronically or in a printed format that make up your personal health record. Your request will be processed within 30 days of receipt.

If you are applying on behalf of someone else, you must provide identification (e.g. birth/marriage/death certificate/s, evidence of Enduring Power of Guardianship) clearly showing that you are the closest living relative to the subject of this application in addition to personal identification. If you are not the closest relative you must provide written authorisation from the closest relative permitting you to amend the information.

On completion, this form can be posted (South Perth Hospital, ATTN Health Information Manager, PO Box 726 COMO WA 6952) or emailed to: info@sph.org.au (marked ATTN Health Information Manager).

Name of Applicant Mr/Mrs/Miss/Ms (circle)	Date of Birth:
Surname:	First Name:
Previous Surname (if applicable)	
Postal Address:	
Contact Details	
Phone (H)	(M)
(W)	email

Details of Information to be Amended *Describe clearly the information you wish to amend. Please include document title/author, dates, or any other irrelevant information where possible.*

Reason Amendment *Please tick the appropriate box to indicate why the information requires an amendment:*

☐ Inaccurate ☐ Incomplete ☐ Out of Date ☐ Misleading ☐ Other, specify _____

Please outline the reason/s why you believe the information is inaccurate/incorrect/out of date/misleading

Form of Amendment *Please tick the appropriate box*

☐ Alteration ☐ Insertion ☐ Insert a file note

Please outline the changes you request.

Are you applying for information about another person? □ **Yes** □ **No**

Your relationship to this person:

Person's Full Name:

Person's Date of Birth:

Documentation Provided *Please tick appropriate box/s*

☐ **Driver's License** ☐ **Passport** ☐ **Birth Certificate** ☐ **Marriage Certificate** ☐ **Death Certificate**

☐ **Enduring Power of Guardianship** ☐ **Letter of Authorisation** ☐ **Other** *(specify)*

Applicant's Signature:	**Date:**

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Office Use Only	
Date received:	**Patient UMRN:**

	Yes/No/ NA
Acknowledgement sent	
Proof of Identity sighted/received **Type** *(tick)* ☐ **Driver's License** ☐ **Passport** ☐ **Birth Certificate** ☐ **Marriage Certificate** ☐ **Death Certificate** ☐ **Enduring Power of Guardianship** ☐ **Letter of Authorisation** ☐ **Other** *(specify)*	
Amendment approved	
Name of authorising person	
If request for amendment denied, state reason here	
Information Amended **Date**	
How amended *(tick)* ☐ **Alteration** ☐ **Insertion** ☐ **Insert a file note**	
Name & Signature of Amending Officer:	