South Perth Hospital

REQUEST TO ACCESS

A

PATIENT RECORD

Your right of access, under the Privacy Amendment (Enhancing Privacy Protection) Act 2012, you generally have the right to access 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.

An administration fee will apply (see below).

Granting access, 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 access 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 Request *Describe clearly the documents you wish access. This includes dates, subject matter or any other information that would help us to identify the documents you are seeking.*

Reason for Request *Please outline the reason you wish to access these documents (e.g. personal interest, ongoing care or legal matter)*

Form of Access *Please tick the appropriate box*

☐ I wish to inspect the documents ☐ I require a copy of the documents

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)*

Fees

I acknowledge that I must pay for the provision of the documents requested herein.
A charge of $95 (inc GST) applies to all patient/individual requests for medical records/information.

Applicant's Signature:	**Date:**

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

	Yes/No/ NA
Accountant contacted	
Invoice generated	
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)*	
Payment received	
Release approved	
Name of authorising person	
If request denied, state reason here	
Information released **Date**	
How released *(tick)* ☐ **Collected in person** ☐ **Viewed** ☐ **Faxed** ☐ **Mailed** ☐ **email**	
Name & Signature of Releasing Officer:	