Clutha Health First is required to safeguard your personal information by ensuring that only you or designated persons named by you have access to your medical records. You must therefore personally identify yourself as that person by signing the attached request form.

If you wish to view your clinical records you must do so under supervision and must not alter, deface or remove any information. You may request a correction page be inserted appropriately into the

Identification

Identification is necessary to access records. Please supply evidence with your application and/or present ID to Medical Records staff. This could be your driver's licence, passport or community services card.

You will need signed authority and proof of identity to access the medical records of someone else. If you are accessing the records of a child you will need to supply evidence of the relationship you have with that child i.e birth/adoption certificate, or guardianship documents.

Medical information regarding a deceased person will be released only with the written consent of the executor or administrator of the deceased estate which is to be provided with the request.

Response Time

We are required to act on requests within 20 working days. If there is going to be a delay in responding to your request we will inform you of this.

Telephone Requests

Anyone requesting information over the telephone will be supplied with a Request to Access Clinical Information Form which needs to be completed and

Copies of Information

Copies are free of charge.

You may request copies of part or all of your clinical record. However, if your clinical record has been inactive for more than 10-15 years it may have been destroyed. We will check first and inform you if this is the case.

This request form will be placed in the patients file when the information is viewed, collected or sent.

Refusal to Access

Clutha Health First may refuse you access or disclosure of certain parts of your clinical record under the provision of the Health Information Privacy Code 1994. We will state the reason for such a refusal and you do have the right of review of the decision through the privacy commissioner.

Parents and Guardians

Parents and Guardians have a limited right of access to their children's information under the age of 16 as per section 22F of the Health Act

Further Information

Further information can be found at:

- www.privacy.org.nz
- Health Information Privacy Code 1994
- Privacy Act 1993
- Official Information Act 1982

Access to Clinical Information

Medical Records

Phone (03) 419 0500

Clutha Health First
Hauora Tahi Ki Iwikatea
Community Health

Request to Access Clinical Information

Clutha Health First
Hauora Tahi Ki Iwikatea
Community Health

Please Indicate the type of information you are seeking:

- ○ Access to your Personal Information
- ○ Access to your Childs Personal Information
- ○ Access to a Deceased Person's Information
- ○ Granting another Person Access to your Information

Full Name of Patient: _____

Other names known by: _____

Date of Birth: _____ NHI: _____

Full Residential Address: _____

Email Address: _____

Contact Number Day: _____ Mobile: _____

Date the information is required and state reason (if urgent): _____

Email Address: _____

Manner in which information is requested: ○ Collect ○ View under supervision ○ Email* ○ Post/Courier

*Clutha Health First does not recognise e-mail as always being a secure means of providing information and cannot take any responsibility for information that is accessed or received by others. If, however you would like us to e-mail you the personal health information you have requested, please initial here:_____

I request to view and / or have copies of medical records for:

Please indicate the service you require information from and if possible the date(s) applicable.

- ○ Inpatient Admission Date(s): _____
- ○ Maternity Record Date(s): _____
- ○ Outpatient Appointments Date(s): _____
- ○ Community (Specify Dept:) _____ Date(s): _____
- ○ General Practice Record Date(s): _____

Full Name of Patient: _____

Signature: _____ **Date:** _____

Full Residential Address: _____

Contact Number Day: _____ **Mobile:** _____

Consent Process: Complete appropriate section only

Personal:

I consent to accessing my own information.

Signature: _____ Date: _____

Child under 16 years of age

Full Name: _____ Relationship to Child: _____

Address: _____

Contact Number Day: _____ Mobile: _____

Is there a counsel for the child? **YES / NO**

If YES, Name: _____ Contact Number: _____

I certify that there are no protection orders issued in my name by the courts restricting access to any of the information held in the clinical record.

Consent by Patient Administration/ Representative to Access Information

Patient is deceased and I am the trustee / executor / administrator of the estate (copy attached)

I hold an active Enduring Power of Attorney relating to health and welfare (copy attached).

Name: _____ Date: _____

Signature: _____ Relationship to Individual: _____

Address: _____

Daytime Contact Number: _____

Authorisation to Disclose Personal Information to a Third Party

I: _____ Signature: _____

Authorise that access be granted to the below named individual to view / have copies / collect the copy of the named individual clinical record(s) as indicated above.

Name of Person to Release to: _____

Relationship: _____ Daytime Contact Number: _____

Address: _____

For Office Use Only: **On completion File in Clinical Record**

Request Recieved: _____ Request Approved: **O** YES **O** NO

If not approved, state reason: _____

Form of ID: **O** Drivers License **O** Passport **O** Other_____ Id Verified: **O** Yes **O** No

O Information released to patient/agent Date of release: / /

Name and Signature of patient or agent receiving information: _____

Processed by staff: (sign) _____ Date: / /

File viewing appointment: _____ Date: / /