Clutha Health First
Hauora Tahi Ki Iwikatea
Community Health

Office Use Only: Date Request Received

Release of Personal Health Information Request Form

Please ensure all sections of this form are completed in full and provide the required supporting documentation so your application can be processed.

Patient Details – Person whose Records are to be Accessed			
Surname/Family Name		Given names:	
Date of Birth		NHI Number: (if known)	
Also known as/other/ previous names:			
Residential Address:			
Postal Address (if different):			
Mobile number:		Phone number:	
Email Address:			

Requestors Details – Complete if Requesting Someone Else's Records			
Requested by (full name):			
Relationship to Patient:			
Mobile number:		Phone number:	
Postal Address:			
Email Address:			

Basis for Request (select ONE):	Supporting Document(s) Required
☐ I am the patient requesting my own information	☐ Photo identity (for example, Driver Licence, Passport)
☐ I am the parent/legal guardian of the child who is under 16 years of age	☐ Photo identity (proof of relationship will be required) ☐ Are there any current Court Orders in place in relation to this child? If yes please provide us with a copy
☐ I have signed consent from the patient	☐ Signed consent by Patient and Photo identity of Patient ☐ Photo identity of Requestor **Patient Signature:**
☐ Other agency request with authorisation already collected/signed consent	☐ Copy of signed documentation authorising release of specified information, or consent signed by Patient **Patient Signature:**
☐ I have lawful authority over the patient's affairs	☐ Photo identity and copy of lawful authority (for example, activated EPOA or PPPR)
☐ I have authority as, or consent from, the Executor/Administrator of the deceased estate	☐ Photo identity and copy of relevant page from the Will or Letter of Administration.
☐ Other – please provide details:	

Signature of person who will be receiving the information
Please read REQUESTING HEALTH INFORMATION FACT SHEET before signing form

Name			
Signature		**Date:**	

Urgent Request – Detail of Why an Urgent Request is Required	
DATE required by (ASAP not accepted):	
REASON for urgency*:	

*Every effort will be made to meet required timeframes, but this may not always be possible. In accordance with the Privacy Act 2020, we will respond to your request no later than 20 working days after date of receipt.

Date Range of Information Required	
☐ One admission/treatment (e.g. 1-10 June 2020) Admission Date:	☐ Date range (e.g. Feb to Jun 2020) Date Range:

Information Requested: select the categories of information required for	
PATIENT NAME:	
☐ Inpatient Records	☐ General Practice / Primary Care Records
☐ Community - Allied Health / District Nursing	☐ Maternity Records
☐ Test results, e.g. Bloods, X-rays etc (please specify):	
☐ Other Information (please specify e.g. Outpatients):	

Delivery Details – Please Select ONE Option		
☐ Courier to Requestors postal address (signature required)	☐ Electronically	☐ Collect from Clutha Health First

Returning Completed Form Options
Please return this completed, signed form with supporting copies of required documentation to If you need assistance or have questions relating to completing this request form, please contact us at this email address

Office Use Only (Complete where applicable)					
Date request received		Staff member who received			
Photo ID verified	☐ Yes	**OR** Security questions answered		☐ Yes	
Form of ID used to verify		ID Expiry Date			
Contact required before commencing process:	☐ Yes ☐ No	Reason if Yes			
Name of staff member who compiled request:					
All documents checked to ensure are for correct patient:	☐ Yes ☐ No	No. of pages sent			
Request Record Spreadsheet Updated?	☐ Yes ☐ No	File Uploaded to Patient Record?	☐ Yes ☐ No		
Release Authorised by		Date:			
Contact required before dispatch of documents:	☐ Yes ☐ No	Reason if Yes			

IF Request declined:	☐ In Full ☐ In Part	Decision made by:	
Reason:			
How Requestor advised of decline	☐ By Phone ☐ Letter /Email		