

## Patient Request to Access Health Records

Please complete relevant sections and **sign patient consent** on page 2

Patient Details		MRN (office use only)
Surname _____ Given Names _____		
Maiden/Previous Name _____		
Date of Birth ____ / ____ / ____ Sex _____		
Address _____		
Phone _____ Email _____		
Please detail if you have one of the following (50% discount may apply):		
<input type="checkbox"/> Healthcare Card <input type="checkbox"/> Pension Card <input type="checkbox"/> Seniors Card <input type="checkbox"/> DVA Card              No. _____		
Requester Details (if different to patient)		
Surname _____ Given Names _____		
Date of Birth ____ / ____ / ____ Sex _____		
Address _____		
Phone _____ Email _____		
Please detail if you have one of the following (50% discount may apply):		
<input type="checkbox"/> Healthcare Card <input type="checkbox"/> Pension Card <input type="checkbox"/> Seniors Card <input type="checkbox"/> DVA Card              No. _____		
Type of Access (please select one)	Fees (legislated determination of fees)	
<input type="checkbox"/> Secured Electronic Copy	Electronic delivery: \$18.95 USB: \$36.70	
<input type="checkbox"/> Printed Copies (posted or picked up from The Canberra Hospital)	For first 50 pages: \$52.10 (Excl. GST) Additional pages: \$0.45 per page	
<input type="checkbox"/> View Record (subject to approval, by appointment only at The Canberra Hospital)	\$18.95 (No GST) Additional fees may apply	
<input type="checkbox"/> Time of Birth	\$18.95 per patient (incl. GST)	
Records Required		
<input type="checkbox"/> The Canberra Hospital (TCH, Woden Valley Hospital) <input type="checkbox"/> Royal Canberra Hospital (records prior to 1991) <input type="checkbox"/> Community Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol and Drug Services <input type="checkbox"/> Justice Health <input type="checkbox"/> Statement of Attendance for ____ / ____ / ____ (does not incur a fee)		
Dates or periods of attendance for which records are required and/or relevant details of the information required: (e.g. discharge summaries, operation reports)		
_____		
_____		
_____		
_____		

## Authority to Access Records (must be completed prior to submitting form)

Grounds for Authority	
I am authorised to access the record because (please select one):	
<input type="checkbox"/> I am the patient	
<input type="checkbox"/> I have the patient's/ parent's/ guardian's written consent	
<input type="checkbox"/> I am the legal guardian <i>(please attach evidence)</i>	
<input type="checkbox"/> I am the executor of the will <i>(please attach evidence)</i>	
<input type="checkbox"/> I have enduring power of attorney that has been enacted <i>(please attach evidence)</i>	
Consent	
I hereby authorise the release of information specified above to the requester named on this form*.	
Signature _____	Print Name _____
Date ____/____/____	Relationship to Patient _____
Are there any Guardianship/Parental Responsibility Orders currently in place? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(provide copies)</i>	
<i>*Parent/guardian consent needed if patient is under 16 years</i>	
Information	
Documentation Required	<b>Please attach copy of photo ID and any applicable additional documents</b>
	<input type="checkbox"/> Photo ID
If applicable:	<input type="checkbox"/> Guardianship Orders <input type="checkbox"/> Parental Orders
	<input type="checkbox"/> Will <input type="checkbox"/> Relevant Concession Card
Return completed form to	Fax to (02) 5124 3316 Or scan and email to <a href="mailto:CHS.HIS.ROI@act.gov.au">CHS.HIS.ROI@act.gov.au</a> Or post to Health Information Service Canberra Hospital PO Box 11 WODEN ACT 2606
Enquiries	Phone (02) 5124 2124 - Option 2 Or email your question to <a href="mailto:CHS.HIS@act.gov.au">CHS.HIS@act.gov.au</a>
Fees	You will be sent an invoice advising of the cost. <b>Payment is required prior to dispatch of documents.</b> Fees are prescribed per ACT Legislation- Determination of Fees.

Office Use Only
<input type="checkbox"/> ID Sighted
Additional Evidence (if required)
<input type="checkbox"/> Guardianship Orders <input type="checkbox"/> Parental Orders <input type="checkbox"/> Will
<input type="checkbox"/> Other: _____
Staff Member Name: _____