

Patient request to access Health Records

Please complete relevant sections and sign patient consent on page 2
Fees apply to **all** requests – see over for further details or Phone (02) 6244 2124 Option 2


Patient Details (one patient per form)			URN: <small>(Office use only)</small>
Surname	Given Names		
Maiden Name (or other previous surnames)	Date of Birth	Sex	
Address	Suburb	State	Postcode
Medicare No.	Pension No. (For 50% discount*)	Phone	Mobile

Requestor (if different to Patient)			
Surname	Given Names		
Relationship to patient	Company		
Address	Suburb	State	Postcode
Phone	Mobile	Fax	

Select Type of Access	Viewing access only (no copies required)
<input type="checkbox"/> View record Fee = \$15.20*	<input type="checkbox"/> I would like to view my record for a fee of \$15.20 (See over for more details regarding fees to view record) Please specify which facility you attended: <input type="checkbox"/> Canberra Hospital <input type="checkbox"/> Woden Valley Hospital <input type="checkbox"/> Royal Canberra Hospital <input type="checkbox"/> Community Health Please specify what you would like to view: <input type="checkbox"/> Attendance on or from ___/___/___ <input type="checkbox"/> Entire Record <input type="checkbox"/> Records from a specialised Unit e.g. Child at Risk, Dental, Foetal Medicine, Mental Health, Radiation Oncology, Sexual Health. Please Specify: _____ <div style="text-align: right;">Please sign consent on page 2</div>
<input type="checkbox"/> Printed Copies Fees start at \$41.70*	<div style="text-align: center; background-color: #e1eef6; padding: 2px;">Printed Copies</div> <input type="checkbox"/> I would like copies of my record for a fee of \$41.70 for first 50 pages, then 35c for each additional page Please specify which facility you attended: <input type="checkbox"/> Canberra Hospital <input type="checkbox"/> Woden Valley Hospital <input type="checkbox"/> Royal Canberra Hospital <input type="checkbox"/> Community Health Please specify what you would like copies of: <input type="checkbox"/> Entire Record <input type="checkbox"/> Summary Documents only (e.g. Discharge Summaries, Operation Reports) <input type="checkbox"/> Specific sections only e.g. <input type="checkbox"/> Inpatient records <input type="checkbox"/> Outpatient records <input type="checkbox"/> Emergency Dept records <input type="checkbox"/> Community-based Services <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Part record from ___/___/___ <input type="checkbox"/> Exclude Observation charts <input type="checkbox"/> Exclude Pathology <input type="checkbox"/> Records from a specialised Unit. Some records are kept separate to the main hospital record. e.g. Child at Risk, Dental, Foetal Medicine, Mental Health, Radiation Oncology, Sexual Health etc. Please Specify: _____ <div style="text-align: right;">Please sign consent on page 2</div>

<input type="checkbox"/> Time of Birth Fee = \$57.75 (inc GST) (pensioner discount not applicable)	Time of Birth (only)	
	<input type="checkbox"/> I would like a search conducted to obtain my exact Time of Birth for a fee of \$57.75 or <input type="checkbox"/> I would like to obtain the exact Time of Birth for my children (under 16 yrs) for a fee of \$57.75 per child	
	Name of Child _____	Date of Birth ____/____/____
	Name of Child _____	Date of Birth ____/____/____
	Name of Child _____	Date of Birth ____/____/____
<input type="checkbox"/> Specific Information Fee = \$57.75 (inc GST) (pensioner discount not applicable)	Specific Information	
	<input type="checkbox"/> I would like specific information for a fee of \$57.75	
	<input type="checkbox"/> Statement of attendance ____/____/____ or <input type="checkbox"/> Medical Certificate for ____/____/____	

Authority to access records	
I am authorised to access the record because <i>(Please tick whichever is applicable)</i>	
<input type="checkbox"/> I am the patient <input type="checkbox"/> I have the patient's/parent's/guardian's written consent (see below) <input type="checkbox"/> I am the patient's next of kin <i>(Only applicable where the patient is a minor (under 16), or where the patient is deceased with no Will)</i> <input type="checkbox"/> I am the Legal Guardian, Executor of the Will or have a Power of Attorney <i>(Please attach evidence)</i>	
Patient/Parent/Guardian's written Consent	
I hereby authorise the release the information specified above to the requestor named on this form.	
Signature: _____ Print Name: _____ Date: ____/____/____	
Relationship to the patient: _____	
Are there any Guardianship/Parental Responsibility Orders currently in place? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Please supply copies)</i>	

More information	
Return completed form to	Fax to (02) 6244 3316 or scan and email to ClinicalRecords.MedicoLegal@act.gov.au or post to Clinical Record Service Canberra Hospital PO Box 11 WODEN ACT 2606
Enquiries	Phone (02) 6244 2124 - Option 2 Or email your question to ClinicalRecords.MedicoLegal@act.gov.au NB Not all records are stored on-site. Please allow up to 4 weeks for processing.
Fees As determined by the ACT Government	The fee for printed copies will be based on the number of pages in the record and will be calculated after the request is received. You will be sent an invoice advising the cost. <p style="text-align: center;"><u>Payment is required prior to despatch of documents</u> (Allow up to 4 weeks for processing)</p> <p><u>Fees</u></p> Photocopy/printed copies of record = \$41.70 for 50 pages, then 35c per additional page* Time of Birth / Medical Certificate / Attendance dates = \$57.75 (Inc GST) View access only (without copies or explanation) = \$15.20 * <p>Note</p> <ul style="list-style-type: none"> * Pension/Health Care Card 50% discount is only applicable for requests by Patients to access their own record – Please supply copy of Pension or Health Care Card (Refer to Disallowable instrument DI2015-294) Discount not applicable for 3rd party requests e.g. solicitors, insurance companies or Time of Birth/Medical Certificate (Refer to Disallowable instrument DI2016-73) If payment of fee will cause undue financial hardship, provide written justification to support waiving of fees Access to view with explanation will require a Doctor's Appointment. Additional Consultation fees may apply
Translating and interpreter service	 <div style="display: inline-block; vertical-align: middle;"> <p>Call 131 450 for a free interpreter.</p> </div>

For all enquires please telephone (02) 6244 2124 – Option 2