

**Request for Record Access**

Under the *Act Health Records (Privacy and Access) Act 1997, Section 7*  
See over for fees: Allow up to 4 weeks for processing

URN: (Office use only)
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**1. Patient (whose record do you want to access?)**  Mine  Someone else's (complete details in sections 1 & 2)

Surname	Given Names			
Maiden Name (or other name)	Date of Birth	/	/	Pension No.
Address	Suburb			Postcode

**2. Requestor**

Surname	Given Names			
Relationship (to patient)	Company			
Address	Suburb			Postcode
Home Ph.	Mobile No.			Fax No.

**3. Information Required (What information do you require)**

Health Facility (please tick)	<input type="checkbox"/> Canberra Hospital <input type="checkbox"/> Woden Valley Hospital <input type="checkbox"/> Royal Canberra Hospital <input type="checkbox"/> Community Based Service (e.g. Tuggeranong Health Centre)	See over page for fees applicable. No GST is payable on requests
Type of Access	1. Copies of the 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 notes <input type="checkbox"/> Outpatient notes <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Community Based Services <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Entire record from ___/___/___ <input type="checkbox"/> Exclude Observation charts <input type="checkbox"/> Exclude Pathology	
	2. Specific Information <input type="checkbox"/> Statement of attendance ___/___/___ <input type="checkbox"/> Medical Certificate for ___/___/___	
	3. Time of Birth <input type="checkbox"/> Mine <input type="checkbox"/> my children (provide additional details below) Name of Child _____ Date of Birth ___/___/___ Name of Child _____ Date of Birth ___/___/___ Name of Child _____ Date of Birth ___/___/___ Name of Child _____ Date of Birth ___/___/___	
	4. Access to view the record (Access to view with explanation will require a Doctor's Appt. Additional Consultation fees may apply) <input type="checkbox"/> of Attendance on ___/___/___    OR <input type="checkbox"/> Entire Record <input type="checkbox"/> Other _____	

**5. Authority**

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

Turn over for additional information

Enquiries:

Phone (02) 6244 3240 or (02) 6244 3241 or (02) 6244 2124

Or email your question to [TCHMedicalRecords@act.gov.au](mailto:TCHMedicalRecords@act.gov.au)

Return completed form to: fax (02) 6244 3316 or post to Clinical Record Service  
Canberra Hospital  
PO Box 11  
WODEN ACT 2606

Fees: The fee is based on the number of pages so will be calculated after the request is received and the record is reviewed.  
PAYMENT IS REQUIRED PRIOR TO DESPATCH OF DOCUMENTS (Allow up to 4 weeks for processing)

Fees

Photocopy of record = \$38.00 for 50 pages, then 30c per additional page\*

Time of Birth / Medical Certificate = \$49.00

View access only (without copies or explanation) = \$14.00 \*

*\*Pension/Health Care Card 50% discount applicable for requests by Patients to access their own record – Please supply copy of Pension or Health Care Card (Note: A discount is not applicable for 3<sup>rd</sup> party requests e.g. solicitors, insurance companies)*

*(If payment of fee will cause undue financial hardship, provide written justification to support request for waiving of fees)  
(Access to view with explanation will require a Doctor's Appointment. Additional Consultation fees may apply)*

ENGLISH	If you need interpreting help, telephone:
ARABIC	إذا احتجت للمساعدة بالترجمة الشفوية، إتصل بالهاتف:
CHINESE	如果您需要口译员帮助，请拨电话:
CROATIAN	Ako trebate pomoć tumača telefonirajte:
DARI	اگر به کمک ترجمه شفاهی ضرورت دارید، به این شماره تلفون کنید:
GREEK	Αν χρειάζεστε διαρμηνέα τηλεφωνήσετε στο:
ITALIAN	Se avete bisogno di un interprete, telefonate al numero:
LAO	ຕ້ອນ ການຄວາມຊ່ວຍເຫລືອກຸ່ມງານແປພາສາ. ໃຫ້ໂທສະສັບຫາ
MALTESE	Jekk għandek bżonn l-għajjnuna t'interpretu, ċempel:
PERSIAN	اگر به ترجمه شفاهی احتیاج دارید به این شماره تلفن کنید:
RUSSIAN	Если вам нужна помощь переводчика, звоните по телефону:
SPANISH	Si necessita la asistencia de un intérprete, llame al:
VIETNAMESE	Nếu bạn cần một người thông ngôn hãy gọi điện thoại:

**TRANSLATING AND INTERPRETING SERVICE**  
**131 450**  
Canberra and District – 24 hours a day, seven days a week

HEALTH CARE INTERPRETERS (02) 6205 3333