RELEASE OF HEALTH INFORMATION

NMDHB Email: Privacyrequests@nmdhb.govt.nz

PATIENT'S DETAILS (RECORDS TO BE ACCESSED)

Full name of Patient:_____ NHI (if known)_____

Other Names Known by: _____

Full Residential Address: _____

Date of Birth: _____

Contact Phone No. (best contact): _____ Mobile No: _____

Email address: _____

Date information required by if Urgent (not asap): _____ Reason: _____

Every effort will be made to meet required timeframes, but this will not always be possible. In accordance with the Privacy Act 1993 40 (1), we will respond to your request no later than 20 working days after date of receipt of request.

REQUESTOR'S DETAILS (if different from above)

Full Name of Requestor: _____

Relationship to Patient: (Authority for requesting information) _____

Full Residential Address: _____

Contact Phone No: _____ Mobile No: _____

INFORMATION REQUESTED

General Medical Record Date of attendance: From _____ To:_____

- ☐ Emergency Department Visit
- ☐ Outpatient Clinic letters (letters/specialty)
- ☐ Investigation reports (e.g. lab/Xray/Bloods/Other)
- ☐ Admission (full)
- ☐ Discharge Summary:
- ☐ Other: _____

Medical Imaging

Radiology reports only date of Injury/ medical treatment: _____
For Medical Images (e.g. Xray, CT, Photo) Costs will be involved.
Please email: Nelson: Radiology.Reception@nmdhb.govt.nz Wairau: ClinicalAdmin.RadiologyWairau@nmdhb.govt.nz

Mental Health & Addiction Service: Date of attendance From: _____ To: _____

CONSENT BY INDIVIDUAL TO ACCESS OWN INFORMATION:

Signature: _____ Date: _____

Proof of identity is required with **ALL** requests for patient information. If you are a patient authorising another person to act as your agent, proof of your agents, and your own, identity is required before Nelson Marlborough Health can release information.

Proof must be attached for deceased and child protection/custody order or guardianship.

Nelson Marlborough Health will accept the following as proof of identity: Driver's License or a valid passport. If unable to produce a Driver's License or Passport **TWO** other forms of ID will be required e.g. Community Service Card, birth certificate.

CONSENT BY CHILD'S LEGAL GUARDIAN OR NEW ZEALAND COURT APPOINTED GUARDIAN, TO ACCESS INFORMATION IF UNDER 16 YEARS OF AGE.

Name:_____ Relationship to individual: _____

Address:_____

Is there a Counsel for the Child: YES ☐ OR NO ☐

If YES – Name:_____ Contact No.:_____

I certify that there are no Protection Orders issued in my name by the courts restricting access to any of the information held as Clinical Records:

Signature:_____ Date: _____

CONSENT BY INDIVIDUAL'S ADMINISTRATOR/REPRESENTATIVE TO ACCESS INFORMATION (CHOOSE BELOW)

I HOLD AN ENDURING Power of Attorney relating to health (attached copy)

OR

The individual is deceased and I am the Trustee/Executor/Administrator of the Estate (attach copy).

Name:_____ Date: _____

Signature:_____ Relationship to Individual:_____

AUTHORISATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

I (print name) _____ Signature: _____

Authorise that access be granted to the below named individual to view/have photocopies/collect the copy of the named individual's Clinic Record(s) as indicated on the front page of this document.

Name of person releasing to:_____ Relationship:_____

Address:_____ Daytime contact no: _____

Medical chart will not be released during open coronial cases. This form and subsequent information are subject to the provisions of the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982.
You will receive a reply within 20 working days unless deemed urgent. Further information is available from the Office of the Privacy Commissioner 0800 803 909 or www.privacy.org.nz

REQUESTOR'S CHECKLIST

- Please ensure you have signed the appropriate sections(s) above. When signing the appropriate section, ensure that relevant copies of "Enduring Power of Attorney" **or** Will **or** Letter of Administration **or** Guardianship papers are enclosed.
- Signature and Photo ID are attached.
- Post completed form with all required attachments

FOR OFFICE USE ONLY

ID Verified: YES/NO Form of ID: Drivers Licence/Passport/Other ID (specify)_____

Request is AUTHORISED: YES/NO - specify reason if NO (or see attached letter) _____

Date Information Released: ----/ ----/ ---- **OR** date information delivered to applicant in person.

Name and signature of person receiving information:_____

Name and signature of staff member processing request:_____ Date: ____/____/____

Information for requests to view or photocopy Medical Records/Health Information held at Nelson Marlborough Health

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Please read the following information before completing the authorisation form.

The Nelson Marlborough Health is required to safeguard your personal information by ensuring that only you have access to your clinical records, or the designated person(s) named by you. You must therefore personally identify yourself as that person by signing the request form (proof of identity must be attached).

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 seek a correction of that information by writing to the Privacy Officer at Nelson Marlborough Health.

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

Under the Privacy Act 1993, we will respond to your request within 20 working days to inform you if and when, the requested information will be available.

Nelson Marlborough Health 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.

Clinical information regarding a deceased person will only be released with the written consent of the Executor or Administrator of the deceased estate. If you are the Executor or Administrator, please provide us with a copy of the relevant documentation as this will help us process your request.

Please return the completed form to:

Clinical Records
Nelson Marlborough Health
Private Bag 18
Nelson
NZ

Ph: 03 5461657
Email: privacyrequests@nmdhb.govt.nz