CMDHB Patient Information Service

PERSONAL HEALTH INFORMATION REQUEST FORM

Patient details - Person whose records are to be accessed	
Surname/family name:	NHI number:
Full given names:	
Also known as:	
Date of birth: / /	
Full residential address:	
Contact Telephone number:	

Requestor details - if different from above
Name:
Relationship to patient:
Full residential address:
Contact Telephone number:
I have the following authority to request this information:
☐ I am the parent or guardian of the child who is under 16 years of age
☐ I am the administrator or executor of the estate of the deceased person
☐ I have lawful authority (such as a power of attorney) over the person's affairs
☐ I have authorisation from the administrator or executor of the deceased persons estate

Information Requested - select the categories of information requested	
☐ Discharge Summary from Inpatient Admission	Date Range:
☐ Clinic Letter from Outpatient Appointment	Date Range:
☐ Laboratory Report	Date Range:
☐ Radiology Report	Date Range:
☐ Obstetric Records	Date Range:
☐ Mental Health Records	Date Range:
☐ General Records	Date Range:
☐ Other (please specify):	Date Range:

Request Details
Date information required:
If the request is urgent please state the reason:
We will try to meet the requested time frame but won't always be possible. In compliance with s40(1) of the Privacy Act 1993 we will respond to your request no later than 20 working days after receiving it.

Signed: ..... Date: .....

NHI number:

Requestor's Checklist

IMPORTANT NOTE: Requests can only be actioned when all necessary documentation is received. Please make sure that you have provided the appropriate documents as per the checklist below.

If you are a patient requesting a copy of your own information:
☐ complete and sign the relevant sections on this form
☐ attach photo proof of ID to this form (e.g. Driver's Licence)
If you are authorised to request the patient's health information:
☐ complete and sign the relevant sections on this form
☐ attach evidence of your lawful authority to this form e.g. Power of Attorney (*activated)*
☐ attach photo proof of your own ID to this form (e.g. Driver's Licence)
If you are requesting a deceased patient's health information:
☐ complete and sign the relevant sections on this form
☐ attach evidence of your lawful authority as administrator/executor of estate to this form e.g. Will, Letters of administration
☐ or if necessary, obtain authorisation from the deceased person's administrator /executor of estate
☐ attach a copy of the completed/signed authorisation to this form along with evidence of their authority
☐ attach proof of your own and the administrator/executor's ID to this form (e.g. Driver's Licence)

Submitting Completed Form

Post completed form with all required attachments to:

Release of Information Clerk
Clinical Record Service
Counties Manukau District Health Board
Private Bag 93311, Otahuhu
AUCKLAND 1640

OR e-mail to: inforequest@middlemore.co.nz

OR fax to: (09) 276 0236

FOR OFFICE USE ONLY

REQUEST APPROVED ☐ NOT APPROVED ☐ ID SIGHTED: YES ☐ NO ☐

ALL DOCUMENTS CHECKED TO ENSURE THEY ARE FOR THE CORRECT PATIENT: YES ☐ NO ☐

DATE RECEIVED: _____

DATE ACTIONED: _____

DELIVERY METHOD: _____

PATIENTS NHI NO: _____

SIGNATURE: _____

NAME (Please print) _____