Waikato District Health Board

Patient's clinical notes release form

Patient's details

Surname / Family name
(include maiden name or any other surnames)

Full first names:

Date of birth:	Gender: Male / Female	NHI number:

Full residential address:

Contact phone number:

Requestor's details - if different from above

Name:

Full residential address:

Contact phone number:

Information requested - please indicate below

☐ **General medical notes:**	Date of admission / Medical treatment: _____/_____/_____
	☐ Discharge summary
	☐ Clinic letters
	☐ Operation reports
	☐ Clinic notes (Nursing assessment / Nursing care record)
	☐ Imaging reports (X-ray, CT, MRI etc) ☐ Copy of X-ray
	☐ Laboratory results
	☐ Other information required *(Please specify)*
	☐ Full records
☐ **Maternity / Obstetrics notes:**	☐ Discharge summary
	☐ Full records
	☐ Other information required *(Please specify)*
☐ **Mental Health notes:**	☐ Discharge summary
	☐ Full records
	☐ Other information required *(Please specify)*

Waikato District Health Board

Patient's clinical notes release form - continued

Individual patient request for copy of own clinical notes

Signature:_____ Date: ____/____/____

Proof of ID is required *- attach to this form when returning it*

Parent/ guardian request for copy of child(ren's) clinical notes

Signature:_____ Date: ____/____/____

Please read statement below* when signing

Relationship to individual:_____

** **IMPORTANT:** I certify that there is no Court Protection Order issued in my name restricting access to the personal information I am requesting.*
Proof of ID is required- attach to this form when returning it

Representative request for copy of patient's clinical notes

Signature:_____ Date: ____/____/____

Relationship to individual:_____

Proof that you are the representative is required. ***ATTACH*** *a copy of the Enduring Power of Attorney for personal care and welfare* ***OR*** *if the individual is deceased, a copy of the Will or Letters of Administration to this request form.* ***Proof of ID is required attach to this form when returning it***

Patient authorisation to disclose own clinical notes to an agent

I, _____ Signature: _____

Insert name

authorise release of my notes to: _____

Proof of ID is required from both patient and agent - ATTACH to this form when returning it

Requestor's checklist

- ☐ If you are a patient requesting a copy of your own information, have you - (i) completed and signed the relevant section(s) on this form; and (ii) attached proof of ID?
- ☐ If you are the representative requesting the patient's clinical notes, have you - (i) completed and signed the relevant sections on this form; (ii) attached a copy of the Enduring Power of Attorney ***OR*** the Will ***OR*** 'Letters of Administration'; and (iii) attached proof of your own ID to this form?
- ☐ If you are an agent requesting a copy of a patient's clinical notes, has the patient - (i) completed the 'Patient Authorisation' (see above) section on this form; (ii) provided proof of his/her ID for you to attach and send with this form; and (iii) have you attached proof of your own ID to this form?
- ☐ If you are requesting a deceased patient's clinical notes, have you - (i) obtained authorisation from the deceased person's 'representative' for Waikato District Health Board to release a copy of the clinical notes to you; (ii) attached a copy of the completed / signed authorisation; and (iii) attached proof of your own and the representative's ID to this form?
- ☐ ***Post*** completed form with all required atiachments to:
  Information Officer, Clinical Records, Waikato Hospital, Private Bag 3200, Hamilton ***OR***
  email to the following email address: *ClinicalRecords@waikatodhb.health.nz*

NOTE: *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.*

OFFICE USE ONLY ID included: Yes / No Form of ID: Driver's licence / Passport

Other ID - *specify*: _____

Name of staff processing request: _____ Signature: _____