Office Use Only: Date Request Received

Te Whatu Ora
Health New Zealand
Te Tai o Poutini West Coast

Release of Personal Health Information Request Form

Please ensure all sections of this form are completed in full and provide the required supporting documentation so your application can be processed.

Hospital this request is for (e.g.) Te Nīkau Hospital:	

Patient Details – person whose records are to be accessed			
Surname/Family Name		Given names:	
Date of Birth		NHI Number: (if known)	
Also known as/other/ previous names:			
Residential Address:			
Postal Address (if different):			
Mobile number:		Phone number:	
Email Address:			

Requestors Details – complete if requesting someone else's records			
Requested by (full name):			
Relationship to Patient:			
Mobile number:		Phone number:	
Postal Address:			
Email Address:			

Basis for Request (select ONE):	**Supporting Document(s) Required**
☐ I am the patient requesting my own information	☐ Photo identity (for example, Driver Licence, Passport)
☐ I am the parent/legal guardian of the child who is under 16 years of age	☐ Photo identity (proof of relationship may be required) ☐ Are there any current Court Orders in place in relation to this child? If yes, please provide us with a copy
☐ I have signed consent from the patient	☐ Photo identity (of Requestor) and signed consent by Patient **Patient Signature:**
☐ Other agency request with authorisation already collected/signed consent	☐ Copy of signed documentation authorising release of specified information, or consent signed by Patient **Patient Signature:**
☐ I have lawful authority over the patient's affairs	☐ Photo identity and copy of lawful authority (for example, activated EPOA or PPPR)
☐ I have authority as, or consent from, the Executor/Administrator of the deceased estate	☐ Photo identity and copy of relevant page from the Will or Letter of Administration.
☐ Other – please provide details:	

Signature of person who will be receiving the information **Please read REQUESTING HEALTH INFORMATION FACT SHEET before signing form**			
Name			
Signature		**Date:**	

Urgent Request – detail of why an urgent request is required	
DATE required by (ASAP not accepted):	
REASON for urgency*:	

*Every effort will be made to meet required timeframes, but this may not always be possible. In accordance with the Privacy Act 2020, we will respond to your request no later than 20 working days after date of receipt.

Date Range of Information Required	
☐ One admission/treatment (e.g. 1-10 June 2020) Admission Date:	☐ Date range (e.g. Feb to Jun 2020) Date Range:
Information Requested: select the categories of information required for	
☐ Discharge Summary/Transfer of Care	☐ Mental Health and Addiction Records
☐ General Medical (Physical Health) Records	☐ Maternity Records
☐ Health Centre (GP)	
☐ Test results, e.g. Bloods, X-rays etc (please specify):	
☐ Other Information (please specify e.g. Bowel Screening):	

Delivery Details – please select ONE option	
☐ Courier to Requestors postal address (signature required) ☐ Post to Requestors postal address	☐ Collection from Main Reception, Te Nīkau Hospital: ☐ Patient is collecting ☐ Other person collecting (must bring photo ID) Name of person:
☐ Electronically	☐ View document (by appointment)
Returning Completed Form Options	
Please return this completed, signed form with supporting copies of required documentation to:	
BY POST *Medical Records Dept, Te Nīkau Hospital and Health Centre PO Box 387 Greymouth 7805*	***IN PERSON*** *Main Reception, Te Nīkau Hospital and Health Centre, High Street, Greymouth 7805*
BY EMAIL *clinicalrecords@wcdhb.health.nz*	
If you need assistance or have questions relating to completing this request form, please contact the Medical Records Department on (03) 769 7400, ext. 5310 or email *clinicalrecords@wcdhb.health.nz*	

Office Use Only (complete where applicable)					
Date request received		Staff member who received			
Photo ID verified	☐ Yes	**OR** Security questions answered	☐ Yes		
Form of ID used to verify		ID Expiry Date			
Contact required before commencing process:	☐ Yes ☐ No	Reason if Yes			
Name of staff member who compiled request:					
All documents checked to ensure are for correct patient:	☐ Yes ☐ No	No. of pages sent			
Request Record Spreadsheet Updated?	☐ Yes ☐ No	File Uploaded to Patient Record?	☐ Yes ☐ No		
Release Authorised by		Date:			
Contact required before dispatch of documents:	☐ Yes ☐ No	Reason if Yes			
IF Request declined:	☐ In Full ☐ In Part	Decision made by:			
Reason:					
How Requestor advised of decline	☐ By Phone	☐ Health Records Counter	☐ Email		

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REQUESTING HEALTH INFORMATION FACT SHEET (please retain for your information)

Information from your own health records, or on behalf of someone, can be requested from Te Whatu Ora. Please ensure all sections of the Release of Personal Health Information Request Form are completed, it has been signed appropriately, and the required supporting documents are supplied with your application. There is no charge for this service.

Requesting your own personal health information?

1 The request must be in writing by completing a Release of Personal Health Information Request Form.

2 Please include as much detail as possible regarding the information you require, including relevant dates. If you are specific about the information you want, we can respond more quickly to your request.

3 **All requests must be accompanied by proof of identification.** To protect the privacy of your personal information we need you to provide proof of your identity. Preferred identification includes a photo and signature (for example driver's licence or passport). If you are unable to provide this, please let us know as soon as possible so an alternative can be arranged.

Requesting health information for a child, relative, friend or deceased relative?

Additional proof will be required for the following requests.

A Child: As above in 1-3.
PLUS - Proof of relationship to the child may be required, for example Birth Certificate.
Note: If the request is for a family member who is **not** a dependant (being a person up to and including 16 years of age) then consent from that person may be required.

Relative or Friend: As above in 1-3.
PLUS - consent from the patient or a copy of the activated EPOA/PPPR (if applicable).

Deceased Relative: As above in 1-3
PLUS - consent from the Executor/Administrator (if not self).
PLUS - a copy of the relevant page from the Will or Letter of Administration.
Note: If there is no Will, a decision on whether to provide access to the records will be made on a case-by-case basis.

How long does it take?

The length of time required to collate information will depend on the volume and nature of information requested, particularly where information is held in different places or systems. So, to help us be able to respond to your request in a timely way, please be as specific as possible about the information you require.

It may take up to 20 working days for us to respond to your request, however, all efforts are made to process all requests as quickly as possible. Incomplete applications may delay the processing of your request. If your request is urgent, you **must** provide a reason for the urgency and the timeframe within which you require the information, and all efforts will be made to meet this timeframe.

If we are unable to meet the 20-day timeframe, we will be in contact with you.

REQUESTING HEALTH INFORMATION FACT SHEET (continued)

Declined Requests

In some circumstances we may refuse part, or all of a request for health information. We will let you know why. You do have the right of review of such a decision and can do this by contacting the Privacy Commissioner.

Retention and Disposal of Information

Under the Health (Retention of Health Information) Regulations 1996 and Public Records Act 2005, depending on the type of health information, the minimum retention period of health information could be 10 to 20 years from the day after the most recent date which an individual was provided services from a provider.

Once the required retention period has passed, rule 9 of the Health Information Privacy Code 2020 says that health information should be disposed of, securely, unless the health agency has a lawful purpose to retain it.

Correcting Information

If you think the information we have provided to you is inaccurate, you are entitled to ask for it to be corrected. Please contact the Quality and Patient Safety Manager on (03) 769 7808, or 022 622 1108 or email quality@wcdhb.health.nz to further discuss this.

Need help with your request?

If you have any questions about any of the information above, please contact the Medical Records Department team on (03) 769 7400, ext. 5310 or email clinicalrecords@wcdhb.health.nz

Privacy Commissioner

Should you be dissatisfied with the information provided to you, a complaint can be raised with the Office of the Privacy Commissioner. Please visit their website https://privacy.org.nz/your-rights/resolving-privacy-issues/ for more information.

This form and subsequent information are subject to the provisions of the Privacy Act 2020, Health Information Privacy Code 2020 and/or Official Information Act 1982.