



MACQUARIE UNIVERSITY
Hospital
3 Technology Place, Macquarie University NSW 2109

APPLICATION FOR ACCESS TO PERSONAL INFORMATION

UR

Surname

Given name

Date of birth

1. PATIENT DETAILS

Title: Mr / Mrs / Ms / Miss Other (please specify) _____

Given

Names

Surname

Any former names

(including maiden names)

DOB

Sex: M / F

Address

Postcode

Home

Phone

Work

Phone

Mobile

Phone

2. IF REQUEST IS ON BEHALF OF ANOTHER PLEASE COMPLETE YOUR DETAILS

Title: Mr / Mrs / Ms / Miss Other (please specify) _____

Given

Names

Surname

Any former names

(including maiden names)

DOB

Sex: M / F

Relationship of

applicant to patient

Address

Postcode

Home

Phone

Work

Phone

Mobile

Phone

CONSENT IF APPLICABLE

If you are requesting access to personal information relating to another person, on their behalf, they must give written consent.

Note: Identification is required from both the patient and the applicant. In the event that the person is deceased, the applicant must have written consent of the person who is the executor of the will and proof they are the executor of the will. If you are the person's legal guardian or attorney, a copy of the guardianship appointment or order, power of attorney or other relevant documentation is required.

I Given
Name

Surname

authorise Macquarie University Hospital to release a copy of personal information relating to

to Given
Name

Surname

Relationship to patient

3. RELEASE OF INFORMATION

I understand that my health record may contain information relating to my medical history and any other conditions not directly related to the purpose for which the information is requested. In particular clinical notes may contain information such as HIV/AIDS (testing, status and result), sexual assault drug & alcohol, aboriginal health, adoption, genetics and organ/tissue donor identification or any other information which I, as a patient define or interpret as sensitive.

I understand that such information may be released unless I specifically state otherwise.

If I have any objections to certain sensitive information being released to the above applicant, I will inform Macquarie University Hospital of any objects in writing.

Name of patient/
parent/guardian

Signature

Date

APPLICATION FOR ACCESS TO PERSONAL INFORMATION

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Surname

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Given name

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Date of birth

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4. REQUESTING NOTES OF MINORS

Applicants for personal information notes of patients <14 years must have parent/legal guardian consent. Where the patient is between 14 and 16 years, consent must be obtained from both the patient and parent/legal guardian unless the patient objects to their parent/legal guardian giving their consent.

5. DETAILS OF REQUEST

☐ Medical certificate ☐ Discharge summary ☐ Work Cover certificate ☐ Dates of attendance ☐ Clinical notes

☐ Other (Please specify)

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Date(s) or period of attendance for which records are required

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6. IDENTIFICATIONS

Two forms of identification are required, preferably photo identification (marked as **), minimum of one with signature. Please tick the appropriate box for documentation provided. Note: Photocopied identification provided must be certified by a Justice of Peace (JP).

☐ Passport (**) ☐ Social security card ☐ Birth certificate
☐ Drivers license (**) ☐ Credit/Debit cards ☐ Medicare card

☐ Other (please specify)

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7. FEE CHARGES AND PAYMENT

The fee schedule is as follows:

Clinical notes (for the first 80 pages, \$0.40 for any additional pages)	\$110
Worker cover/Medical certificate (if not requested and completed during admission)	\$33
Discharge summary	free
Dates of attendance	free

Pensioner/concession card holders are entitled to a 50% discount (proof required).

Cheque or money order should be made payable to Macquarie University Hospital.

Please do not send cash in the mail.

8. INFORMATION FOR APPLICANTS

Please try to provide as much detail as you can to help us identify the information that you require.

Your request will be processed by Health Information Services on the proviso that we have the required Information, fee and relevant authority (where applicable).

For further information please contact Health Information Services on +61 2 9812 3007.

OFFICE USE ONLY

UR

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Date

Received

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ID obtained ☐ Yes ☐ No

Date completed

Receipt

No.

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Processed

by

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Mode of

Delivery

☐ Mail ☐ Pick up

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Comments

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