Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

PO Box 96
Masterton 5840
Phone 06 9469800
Fax 06 9469817
www.wairarapa.dhb.org.nz

Request for Patient Information

PATIENT DETAILS (Records to be accessed)	
Surname/Family Name:	
Full Given Names:	
Also Known As:	
Date of Birth:	
NHI Number:	
Full Residential Address:	
Telephone Numbers:	
Email address	

REQUESTOR'S DETAILS (If different from above)	
Name:	
Residential Address:	
Telephone Number:	

INFORMATION REQUESTED: Please select the categories of information requested	
Date of injury/medical treatment :	
☐	Emergency Department
☐	Outpatient Clinic
☐	Birth Notes: Mother's Name and Maiden Name..... Mother's date of birth: ...../...../.....
☐	Admission and / or ☐ Discharge Summary
☐	Investigations (test results)
☐	Other – please specify:
☐	**Mental Health Services (Includes Child Adolescent)** ☐ Clinical Notes ☐ Investigations ☐ Other

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 response or acknowledgement within 20 working days.

Proof of Identity is required with ALL requests for patient information.
Wairarapa DHB will accept one of the following as proof of ID –
Drivers licence OR valid passport OR other form of ID eg Community Services Card.

(A) INDIVIDUAL PATIENT REQUEST FOR COPY OF OWN CLINICAL NOTES

Signature: _____ Date: _____

Proof of ID is required – attach to this form

(B) PARENT / GUARDIAN REQUEST FOR COPY OF CHILD(REN'S)* CLINICAL NOTES

Signature: _____ Date: _____

Relationship to Individual: _____

IMPORTANT: I certify that there is no Court Protection Order restricting access to the information I am requesting.

- ***Under 16 years of age.***

Proof of ID is required – attach to this form

(C) REPRESENTATIVE REQUEST FOR COPY OF PATIENT'S CLINICAL NOTES

Signature: _____ Date: _____

Relationship to Individual: _____

Proof that you are the representative is required. ***Proof of ID is required – attach to this form***

REQUESTOR'S CHECKLIST

☐ **OPTION A**
If you are a patient requesting a copy of your own information, have you:
a. completed and signed the relevant section(s) on this form; and
b. attached photo proof of ID (e.g. Driver's Licence)?

☐ **OPTION B & C**
If you are the Parent / Guardian / representative* requesting the patient's health information, have you:
a. completed and signed the relevant sections on this form;
b. attached evidence of representative status and/or lawful authority; and
c. attached photo proof of your own ID to this form?

☐ **If you are requesting a deceased patient's health information have you:**
a. completed a "Request of a Deceased Persons Information" Form
b. obtained authorisation, if necessary, from the deceased person's "representative";
c. attached a copy of the completed/signed authorisation; and
d. attached proof of your own and the representative's ID to this form?

* Representative means:

- A parent or guardian of a child **under16** years of age;
- The administrator or executor of the estate of a deceased person (see Option D above);
- Someone acting with lawful authority (such as a power of attorney) over a person's affairs;
- Someone who is acting on behalf and in the best interests of a person

SUBMIT COMPLETED FORM TO:
Health Records Department, Wairarapa Hospital, PO Box 96, Masterton OR
Mental Health Services, Wairarapa Hospital, PO Box 96, Masterton

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 .../.../...

Name & Signature of staff member processing request: _____