Canterbury District Health Board

Release of Health Information

Te Poari Hauora ō Waitaha PATIENT'S DETAILS (RECORDS TO BE ACCESSED)		
Full Name of Patient:	NHI:	
Other Names known by:		
Full Residential Address:		
Date of Birth: Contact Phone:		
Date Information Required if Urgent: (NOT ASAP)/ Reason:		
Every effort will be made to meet required timeframes, but this will not always be possible. In accordance with the Privacy Act 1993 40 (1),		
we will respond to your request no later than 20 working days after date of receipt.		
REQUESTORS DETAILS		
Full Name of Requestor:		
Full Residential Address:		
Contact Number:E-MAIL ADDRESS	:	
INFORMATION REQUESTED		
General Medical Record	Medical Imaging:	
FROM: CHRISTCHURCH, CHRISTCHURCH WOMEN'S	Date of Injury / medical treatment//	
THE PRINCESS MARGARET HOSPITAL, BURWOOD, ASHBURTON & RURAL HEALTH	Report	
Date of Injury / medical treatment//	□ Images (e.g X-Ray, CT, photo)	
Emergency Department	Other – please specify:	
Outpatient Clinic (Specify)	Mental Health Services	
District Nursing	Dates of attendance:	
□ Admission:	from/ to/	
Discharge Summary	Unit(s):	
□ Clinical Notes	(Send requests to: Clinical Records The Princess Margaret Hospital)	
Nursing Assessment / Nursing Care Record	Manner in which Information is Requested	
□ Referrals	Photocopy 🗌 Verbal	
 Operation Report 	CD (Medical Imaging only) View Personally	
 Monitoring Charts 	E-MAIL (<i>Address</i>)	
Investigations		
Other – Please specify:		

Proof of Identity is required with ALL requests for patient information. If you are a patient authorising another person to act as your agent, proof of your agent's and your own identity is required before Canterbury District Health Board can release information.
 Canterbury District Health Board will accept one of the following as proof of identity:- Drivers Licence or photo/signature page from valid passport OR other form of ID, eg, Community Services Card.

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. Further Information is available from the Office of the Privacy Commissioner 0800 803 909 or www.privacy.org.nz Please complete consent details over page

Date

CONSENT BY CHILD'S LEGAL GUARDIAN TO ACCESS INFORMATION IF UNDER 16 YEARS OF AGE		
Name: Relationship to Individual:		
Address:		
Is there a Counsel for the Child: Yes / No		
If Yes Name:Contact Number:		
I certify that there are no Protection Orders issued in my name by the Courts restricting access to any of the information held Clinical Record		
Signature:Date:		
CONSENT BY INDIVIDUAL'S ADMINISTRATOR/REPRESENTATIVE TO ACCESS INFORMATION		
Individual is deceased and I am the Trustee/executer/administrator of the estate. (COPY ATTACHED)		
I hold an enduring Power of Attorney relating to health, copy attached		
Name: Date:		
Signature: Relationship to Individual:		
Address:Daytime Contact Number:		
AUTHORISATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY		
ISignature		
Authorise that access be granted to the below named individual to view / have photocopies / collect the copy of the named individual's clinical record(s) indicated over the page.		
Name of person released to:Relationship		
Address:Daytime contact number		
REQUESTOR'S CHECKLIST		
Please ensure you have signed the appropriate section(s) above.		
When signing the appropriate section, ensure that relevant copies of "Enduring Power of Attorney" or the Will or "Letters of Administration" or Guardianship papers are enclosed		
Post completed form with all required attachments to the Hospital you require the information from. (Address on information sheet)		
FOR OFFICE USE ONLY		
ID Verified: Yes / No Form of ID: Driver's Licence / Passport / Other ID - Specify:		
Request is AUTHORISED Yes / No Specify reason if No: (OR see attached letter)		
Date Information Released:/ OR if information delivered to applicant in person:		
Name and signature of person receiving information:		
Name and signature of staff member processing request:Date/Date/Date/		



Information for requests to view or photocopy Medical Records/ Health Information held at the Canterbury District Health Board.

Please read the following information before completing the authorisation form.

The Canterbury District Health Board is required to safeguard your personal information by ensuring that only you have access to your clinical records, or designated persons names by you. You must therefore personally identify yourself as that person by signing the request form **(proof of identity must be attached)**.

If you wish to view your clinical records, you must do so under supervision and must not alter, deface or remove any information. You may seek a correction of that information by writing to the Privacy Officer at the relevant hospital address below.

You may request copies of part or all of your clinical record. However, if your clinical record has been inactive for more than 10 years, it may have been destroyed. We will check first and inform you if this is the case.

Your request may take up to 20 working days to complete. We will inform you if an extension to this timeframe is required.

Canterbury District Health Board may refuse you access or disclosure of certain parts of your clinical record under the provisions of the Health Information Privacy Code 1994. We will state the reason for such a refusal and you do have the right of review of the decision through the Privacy Commissioner.

Clinical Information regarding a deceased person will only be released with the written consent of the executor, or administrator of the deceased estate. If you are the executor or administrator, please provide us with a copy of the documents- this will help us process your request.

Please return the completed form to the hospital you require the information from as below:

Send requests for Christchurch, Christchurch Womens, Burwood Hospitals to:

Patient Information Office Christchurch Hospital	E-mail: Patientinformation@cdhb.health.nz
Private Bag 4710 Christchurch 8140	

Send requests for The Princess Margaret Hospital, Hillmorton, Templeton and Queen Mary Hospitals to:

The Clinical Records Department The Princess Margaret Hospital P O Box 800 Christchurch E-mail: Medical_Records_TPMH@cdhb.health.nz

Send requests for Ashburton Hospital to:

Medical Information Officer Ashburton & Rural Health Services Private Bag 801 Ashburton 7740