

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

**Hospital(s) this request is for (e.g. Canterbury):**
**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:			

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

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

<b>Name</b>			
<b>Signature</b>		<b>Date:</b>	

### 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

PATIENT NAME:

Discharge Summary/Transfer of Care

Mental Health and Addiction Records

General Medical (Physical Health) Records

Maternity Records

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)

Electronically

### Returning Completed Form Options

Please return this completed, signed form with supporting copies of required documentation to [hnzprivacy@health.govt.nz](mailto:hnzprivacy@health.govt.nz)

If you need assistance or have questions relating to completing this request form, please contact us at this email address

### 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