

Mid North Coast Local Health District
Coffs Clinical Network
Coffs Harbour Macksville Bellingen Dorrigo
 Locked Mail Bag 812, Coffs Harbour NSW 2450

Health Information & Records Service
Email: MNCLHD-CCN-MedLegal@health.nsw.gov.au
Ph: (02) 6656 7448 Fax: (02) 6656 7446

HEALTH RECORDS AND INFORMATION PRIVACY ACT
2002 APPLICATION FORM



Mid North Coast
Local Health District

DETAILS OF PATIENT

Surname: _____ Given Name: _____ Title: _____

DOB: _____ Previous Name (if applicable): _____

Address: _____ Post Code: _____

Telephone no. (Home): _____ (Work): _____

(Mobile): _____ Email: _____

DETAILS OF REQUESTOR

If this request relates to documents of another person, other than the above named, please complete this section

Surname: _____ Given Name: _____ Title: _____

DOB: _____ Relationship to patient: _____

Address: _____ Post Code: _____

Telephone no. (Home): _____ (Work): _____

(Mobile): _____ Email: _____

DETAILS OF REQUEST

Date/s or period of attendance to the facility which you require: _____

Describe clearly the documents required: _____

For what purpose/reason do you require the documents: _____

FORM OF ACCESS

I wish to view the documents (Payment NOT required). For *VIEWING ONLY* of documents, the Health Information & Records Service will arrange an appointment for you

I require a copy of the documents

To be collected from CHHC - Name of person collecting _____

To be posted to _____

To be sent electronically to _____

PAYMENT

\$33 fee is enclosed. I understand that additional costs may be incurred if documents required exceed 80 pages.

\$16.50 fee is enclosed. I understand that additional costs may be incurred if documents required exceed 80 pages. I have included copies of documents for reduced fee.


Discharge summary only – no fee required.

This is to certify that the details on this form are correct to the best of my knowledge. I have read the Information for Applicants (see over) and understand that full payment and appropriate identification is required before documents are processed and released.

SIGNATURE..... **DATE**.....

PRINT NAME.....

HRIP ACT 2002 APPLICATION FORM

| | |
|---|--|
| <p align="center">Mid North Coast Local Health District Coffs Clinical Network</p> <p>Coffs Harbour Macksville Bellingen Dorrigo Locked Mail Bag 812, Coffs Harbour NSW 2450</p> |  <p align="right">Mid North Coast Local Health District</p> |
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HEALTH RECORDS AND INFORMATION PRIVACY ACT 2002 APPLICATION FORM

By using this form information is requested under the Health Records and Information Privacy Act 2002.
Please provide as much detail as you can to help us identify the documents you require.

NOTE: If you are requesting a medical record that pertains to another person, the **written consent** of that person will be required. In the event the person is deceased, the applicant **MUST** have the consent of the **next of kin** and/or **executor of the will**. Proof of this relationship will be required.

For further information, please contact:

The Health Information & Records Service on 6656 7448 between 7.00am and 3.30pm, Monday to Friday.

Fees and charges:

Under the NSW Department of Health Policy Directive PD2006_050 and Information Bulletin IB2019_036, the charge for providing a copy of the medical record, or part thereof, to a maximum of 80 pages, is \$33 (including GST). The charges above include search fee, photocopying charges, labour costs, administrative charges and postage. A reduced fee of \$16.50 is applicable with proof of Health Care Card/Social Security Card. Provision of a copy of a medical record in excess of 80 pages will be charged at an additional 41 cents per page. **(Applicants will be informed if extra charges apply and the balance must be paid prior to processing and release of the documents).**

Please note: All care will be taken in despatching a copy of medical records to your nominated address but we cannot take responsibility for missing documents sent in the mail.

Applicant identification:

Applicants are required to provide two forms of identification before the medical record can be released. Identification must consist of one from column A and one from column B. Acceptable forms of identification are listed below:

- | A | B |
|--|---|
| <input type="checkbox"/> Passport | <input type="checkbox"/> Birth Certificate |
| <input type="checkbox"/> Citizen Certificate | <input type="checkbox"/> Social Security Card |
| <input type="checkbox"/> Current Driver Licence | <input type="checkbox"/> Employment ID (without photo) |
| <input type="checkbox"/> Public Service ID (Photo) | <input type="checkbox"/> Medicare Card |
| <input type="checkbox"/> Social Security Card (Photo) | <input type="checkbox"/> Credit/Debit Cards, Pass Books |
| <input type="checkbox"/> Tertiary Education ID (photo) | <input type="checkbox"/> Utility Bills |
| <input type="checkbox"/> Employment ID (Photo) | <input type="checkbox"/> Membership Card |
| <input type="checkbox"/> Credit Card (Photo) | <input type="checkbox"/> Education Institutions, Union or Trade Card, Professional Bodies |

FOR OFFICE USE ONLY

Date Received: _____ Receipt No.: _____ Fee: _____

HRIP No: _____ ID obtained: [] Yes [] No Consent Received: [] Yes [] No [] N/A

Viewing date (if applicable): _____ Viewing supervised by: _____

Processed by: _____ Date completed: _____