

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct patient label

Release of Information

All sections of this form must be completed or your application can not be processed

PATIENT DETAILS

Patient Hospital Number (NHI): _____

FAMILY NAME: _____

GIVEN NAME(S): _____

PREVIOUS FAMILY NAME: _____

ALSO KNOWN AS: _____

GENDER: Male / Female Mr Mrs Ms Miss Other _____

Date of Birth: _____

Residential Address: _____

Postal Address (if different from above): _____

Phone Number (Home): _____ (Mobile): _____

REQUESTOR DETAILS

Requestor Name: _____

Postal Address: _____

Phone Number (Home): _____ (Mobile): _____

Relationship to Patient / Authority for requesting information: _____

REQUEST DETAILS

View Record **OR** Receive Copies of documentation

Type of Information Required: Inpatient Information Outpatient Information

Key Information only: _____

Approximate dates: _____

Discharge Summary Clinic letters Radiology Report Latest correspondence
 Radiology CD Laboratory Report

OR Complete copy of clinical record. Please specify: _____

Appointment Dates / Service: _____

Information will be from the following hospital:

Green Lane National Women's Auckland Starship
 Mental Health – Facility name: _____ Other _____

Date Information Required: _____ Urgent? Yes No

If this request is **URGENT** please state reason: _____

Every effort will be made to meet the requested time frame, 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.

INFORMATION DELIVERY DETAILS

To be collected in person Standard Mail Courier Post
 Fax (only for urgent requests)

Consent:

I confirm that the details provided above are true and accurate.

Requestor Signature: _____ Date: _____

ID Sighted Type of ID: _____ Number: _____

Office Use Only

ROI Number: _____ **Date Received:** _____

Information Sent:

File Viewed: Copies Given: Faxed: Courier Post: Standard Mail:

Date Completed: _____ **Name:** _____

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