Queensland Government

APPLICATION FOR ADMINISTRATIVE ACCESS TO HEALTH RECORDS

For office use only
(*Attach Patient ID Label*)

DETAILS OF APPLICANT (Please print)

Full Name	Title (Mr/Mrs/Ms etc)	Surname/ Family Name	
	Given Names		Date of Birth (dd/mm/yy)
	Name used in records (If records requested are under a different name than above, please provide details):		
Postal Address			
	Suburb/Town		Postcode
Tel (Home)	(Work)	(Mobile)	E-Mail

DETAILS OF APPLICATION

It will help us locate the documents without unnecessary delays if you can provide as many details about the documents as possible, including: in what name they are held (eg. under a maiden name); the hospital or health facility where they are held; the date(s) of treatment to which the application applies.

I REQUEST ACCESS TO THE FOLLOWING DOCUMENTS:

☐ IN-PATIENT HOSPITAL NOTES	OUT-PATIENT NOTES	COMMUNITY HEALTH SERVICE NOTES	X-RAYS; MRI SCANS, ETC	LABORATORY REPORTS

(Approximate dates of records requested):

_____

RECORDS OF TREATMENT ARISING OUT OF MOTOR VEHICLE ACCIDENT ON _____(Date)

OTHER (Please specify):

EVIDENCE OF IDENTITY

Before access to personal information can be given, you must provide suitable evidence of your identity. (see over for acceptable forms of documentation) Evidence of identity documentation accompanies this form. YES NO	If you are requesting personal information in respect of another person, the written consent of that person is also required. A copy of the person's written consent accompanies this form. YES NO

Privacy Notice

The Townsville Hospital and Health Service is subject to the Information Privacy Act 2009 and the Right to Information Act 2009. The Townsville Hospital and Health Service manages personal information in accordance with the IP Act. Personal information supplied in the course of an access application may be used or disclosed in order to deal with the application. Your personal information will not be disclosed to any third party without your consent, unless authorised or required by law.

SIGNED: _____ **DATE:** _____

NOTE: **DOCUMENTS WILL NORMALLY BE AVAILABLE WITHIN 25 WORKING DAYS AFTER RECEIPT OF COMPLETED APPLICATION AND CONFIRMATION OF IDENTITY/CONSENT. YOU WILL BE NOTIFIED IF THAT DEADLINE CANNOT BE MET.**

EVIDENCE OF IDENTITY

To protect patient privacy, satisfactory evidence of identity is required before you can be given access to health information. This can be established by providing one of the following identity documents:

Driver licence
Medicare or health benefits card
Birth certificate or certified extract from birth register
Marriage certificate
Identifying page of current passport
Naturalisation certificate or citizenship certificate
Immigration papers or other documents issued by the Commonwealth Department of Immigration.

IF APPLYING IN PERSON: Bring an **original** identity document, for sighting/verification by a departmental officer.

IF APPLYING BY MAIL: Send with your application a photocopy of one of the identity documents listed above.

Mailing address The Townsville Hospital
Release of Information
PO Box 670
Townsville Qld 4810

NOTE: The photocopy must bear the **original** signature of a Commissioner for Declarations or a Justice of the Peace (JP), certifying the photocopy to be a true copy of the original document, which they have sighted. Documents that bear a photocopied or facsimile copy of the certification/signature will not be accepted.

DO NOT SEND ORIGINAL IDENTITY DOCUMENTS THROUGH THE MAIL.

FOR OFFICE USE ONLY

Date received		Officer's Signature			
Identity confirmed	YES	Officer's Signature	Date	NO	**If "NO", application is refused**
Type of ID provided					
Consent verified	YES	Officer's Signature	Date	NO	

† PROCESSED UNDER ADMINISTRATIVE ACCESS

Release authorised by	Officer's Name	Officer's Signature	Date
Documents released by	Officer's Name	Officer's Signature	Date

Method of release	Personal attendance	Registered Mail - Acknowledgment of receipt	
	(Applicant's Signature)	(Attach receipt)	

OR

REFERRED FOR PROCESSING UNDER RIGHT TO INFORMATION / INFORMATION PRIVACY ACTS

Referred by	Officer's Name	Officer's Signature	Date
Reason for referral			