

**REQUEST FOR PATIENT/CLIENT HEALTH INFORMATION**



To: The Patient Information Officer  
 Patient Information Services  
 Capital and Coast District Health Board  
 Private Bag 7902  
 WELLINGTON  
 Ph:(04) 806 2637 – Fax:(04) 385 5812

Please supply a copy of photo ID  
**e.g. Drivers Licence, passport**  
 (If neither of these are available, your Birth Certificate verified by a Justice of the Peace will be accepted.)

<b>PATIENT/CLIENT DETAILS</b>	
<b>Surname(s)</b> .....	<b>Date of birth</b> /     /
<b>All other given Name(s)</b> .....	<b>NHI number (if known)</b> .....
<b>Maiden Name</b> .....	
<b>INFORMATION REQUIRED</b>	
<b>Location:</b>	<input type="checkbox"/> <b>Wellington</b> <input type="checkbox"/> <b>Kenepuru</b> <input type="checkbox"/> <b>Porirua</b>
<b>Type of file being requested:</b>	<input type="checkbox"/> <b>General</b> <input type="checkbox"/> <b>Mental Health</b> <input type="checkbox"/> <b>Other (Dept)</b> (Please specify) ..... <input type="checkbox"/> <b>Maternity File Only - Mother's name</b> ..... Mother's d.o.b.     /     /                      Child's d.o.b.     /     /
I would like information on the following: • <b>Event(s)</b> ..... • <b>Year(s)</b> ..... <input type="checkbox"/> I wish to view the record(s) at the hospital     or <input type="checkbox"/> I would like a photocopy sent to me	
<b>Requestor's authority</b>	<input type="checkbox"/> <b>I am requesting my own information</b> (Signature).....     Date / / <b>OR</b> <input type="checkbox"/> <b>I am requesting information about another person and may do so because:</b> <input type="checkbox"/> The patient's written authorisation is set out below <input type="checkbox"/> I am a parent acting as the representative of a child under 16 yrs <input type="checkbox"/> The patient is deceased and I attach authorisation <input type="checkbox"/> The patient is unable to give authorisation because..... ..... and I have authority as..... ..... Signature: .....     (Date)     /     /
<b>Patient/Client Authorisation (if required)</b>	I, (name).....authorise Capital & Coast District Health Board to release the information as requested above. Signature: .....     (Date)     /     /
<b>Requestors Contact Details</b>	Postal Address: ..... ..... Tel: .....     Fax: .....     Email: ..... Can a message be left ? Yes / No - please tick