

## REQUEST FOR INFORMATION

### Patient details - records to be accessed

Surname/family name:

Full given names:

Also known as:

Date of birth:        /        /               NHI number:

Full residential address:

Contact:                             Telephone number:

### Requestor's details - if different from above

Name:

Full residential address:

Postal address:

Contact:                             Telephone number:

## INFORMATION REQUESTED

### General medical record - select the categories of information requested

Date of injury/medical treatment:        /        /

Emergency Department

Outpatient Clinic  
(e.g. Ophthalmology, Cardiology etc. includes reports from Doctors, Nurses, referrals from GPs)  
Specify:

Birth notes (Please provide mother's details):  
Mother's name and maiden name:  
Mother's date of birth:        /        /

Admission         All admissions         Discharge summary

Investigations (test results)

Other – please specify:

Mental Health Services  
(Includes Community, Inpatient, Alcohol & Other Drug, Child Adolescent & Family, Intensive Rehabilitation, Early Intervention)

**BEFORE SUBMITTING YOUR FORM, PLEASE REFER TO THE REQUESTOR'S CHECKLIST**

## REQUESTOR'S CHECKLIST

### Option A

If you are a patient requesting a copy of your own information:

- complete and sign the relevant section(s) on this form
- attach photo proof of ID (e.g. Driver's Licence)

### Option B

If you are the representative\* requesting the patient's health information:

- complete and sign the relevant sections on this form
- attach evidence of representative status and/or lawful authority
- attach photo proof of your own ID to this form

### Option C

If you are requesting a deceased patient's health information:

- complete Appendix 1, attached to this form
- obtain authorisation, if necessary, from the deceased person's "representative"
- attach a copy of the completed/signed authorisation
- attach proof of your own and the representative's ID to this form

\* Representative means:

- a parent or guardian of a child under 16 years of age;
- the administrator or executor of the estate of a dead person (see Option C above);
- someone acting with lawful authority (such as a power of attorney) over a person's affairs;
- someone who is clearly acting on behalf and in the best interests of a person who is unconscious and/or incapable

## REQUESTOR'S AUTHORITY

I am requesting my own information.

Signature:

Date:            /            /

## SUBMITTING COMPLETED FORM

**Post completed form with all required attachments to:**

Patient Information Officer  
Patient Information Services  
Capital & Coast District Health Board  
Private Bag 7902  
WELLINGTON 6242

**OR e-mail to:** [medrec.patientinf@ccdhb.org.nz](mailto:medrec.patientinf@ccdhb.org.nz)

**OR fax to:** (04) 385 5873

## APPENDIX 1: REQUEST FOR A DECEASED PERSON'S INFORMATION

## Patient Information Services

This form **MUST** be completed by the deceased person's "representative"

In general, Capital & Coast District Health Board cannot release information about a deceased person unless it is being released to, or has been authorised by, the deceased person's "representative".

The term "representative" means the Executor or Administrator of the estate of a dead person.

The representative must complete all parts of this form (below), as well as the relevant parts of the general Request for Information form.

The representative must also provide the following:

- A copy of the front page of the deceased person's "Will" or "Letters of Administration" as proof that s/he is the deceased person's representative; and
- Photo proof of the representative's identity (e.g. Driver's Licence).\*

\* This is not required where the representative is either acting in their professional capacity as a Barrister & Solicitor of the High Court of New Zealand or a Trustee Corporation.

<b>A</b>	
<b>I am the Executor OR Administrator (delete one) of</b>	
..... who died .....	
<i>Print deceased person's name</i>	<i>Print year or date of death</i>
<b>B</b>	
<b>I authorise Capital &amp; Coast District Health Board to release the information indicated on the "Request for Access to Health Information" form (attached) to</b>	
.....	
<i>Print name of person the information is to be released to</i>	
<b>C</b>	
<b>Name:</b>	<b>Address:</b>
<b>Signature:</b>	
<b>Telephone (home):</b>	<b>Telephone (Mobile):</b>
<b>D</b>	
<input type="checkbox"/> <b>I attach a copy of the Will/Letters of Administration (delete one) as proof that I am the deceased person's representative.</b>	
<input type="checkbox"/> <b>I attach a copy of photo ID as proof of my own identity.</b>	

The completed forms and all additional required attachments should be posted, emailed or faxed to Capital & Coast District Health Board.

Please note that where there is no Executor or Administrator, requests for a deceased person's information can be made in writing to Capital & Coast District Health Board's Privacy Officer under the Official Information Act 1982.

If you have any questions about this process, please contact Capital & Coast District Health Board's Privacy Officer.

This form and subsequent information are subject to the provisions of the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982.

You will receive a response or acknowledgement within 20 working days.