Health Record Access Form

For clients requesting access or to transfer of health records out of Your Community Health.

Please complete this form and send it to the Health Information Officer, by mail or at reception: 125 Blake Street, East Reservoir. VIC 3073, or by email: healthrecords@yourcommunityhealth.org.au.
Make sure you attach all documents required – see the checklist.

Your details (the applicant)

We collect your details so it can respond to your application; it will only use your details for this purpose.

Where your full details are not provided, your application for access to documents may be affected.

First Name:_____ Surname:_____

Other names known by: _____

Postal Address:_____

State: _____ Postcode:_____ Telephone: _____

Email (if preferred method of communication):_____

Date of Birth: (day)_____(Month)_____(Year)_____

Do you consent to Your Community Health disclosing your identity and knowledge of this application to other persons for any reasonable consultations necessary for processing your application? (E.g. Consultations may be with individuals also listed in the documents you seek.) Yes □ No □

! Please provide a copy of your identification with a signature (e.g. Australian Drivers Licence, Australian Passport, or a certified copy of your Medicare Care Card, Health Care Card, Pension Card or Veteran Card)

Client Details

We need to know whose health information you are seeking.

We require proof that you have authority to access health information about another person.

Are you seeking access to documents about yourself or other people?
Myself □ Other people □ If yourself, you do not need to complete this section.

Documents about other people.
If you are you are seeking access to documents about a person other than yourself, please provide information that would assist us identify them.

First Name:_____ Surname:_____

Other names known by: _____

Postal Address:_____

State: _____ Postcode:_____Telephone:_____

Date of Birth: (day)_____(Month)_____(Year)_____ Relationship to you:_____

Do these people know that you are requesting access to their information? Yes □ No □

We may need to contact these people while we processes your application.

! Please provide proof that you have authority to act for the person (client) e.g. Will, Power of Attorney

If the person is deceased, please provide contact details for their next of kin

_____

Your Community Health is bound by Commonwealth and Victorian privacy laws, therefore any information you provide is used only for the purpose of making enquiries to respond to your request for access to your health information.

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Details of the request for access or transfer. You have the right to access your health record and request correction to information. The decision to grant access will be based on legislation and the health privacy principles. For more information, please see the "Keeping your information private" flyer and the "Client Information Privacy Policy" on our website.	**What is the reason for your request?** _____ _____ 1. **How would you like to access the health record?** a. View the record at one of the Your Community Health centres - Please circle your preferred centre. East Reservoir Northcote Preston (PANCH) b. View the record with explanation □ • Do you require an interpreter? Y □ N □ If yes, which language: _____ c. Receive a photocopy of the record □ We will send the record by registered post. d. Receive an electronic copy of the documents □ We will provide you with a CD 2. **Do you want to access all, or part of your record?** All □ Part □ If partial access is required, please clearly describe the information you require: _____ _____ 3. **Transfer the health record** to another organisation e.g. GP, lawyer, insurance company □ Please provide the organisation details: First Name:_____ Surname:_____ Postal Address:_____ State: _____ Postcode: _____ Telephone:_____ Company (if applicable): _____ Phone: _____
The next steps	• We will assess your request in accordance with the Health Records Act 2001, and will contact you within 45 days of receiving this form. • Costs may be associated with your request in line with the Health Records Act 2001. When we contact you, we will let you know if there are any costs.
Your Signature	Please sign:_____ Date: _____
Checklist **Have you?**	! Attached some form of signed or certified identification? □ ! Given a clear explanation of the documents you want to access or transfer? □ ! Attached documents to support your application to access information about other people? □ ! Signed this form in the space above? □
Queries?	If you have any further queries or require assistance in completing this form, please contact the Health Information Officer on (03) 8470 1111. Information about our Privacy Policy can be found on our website: www.yourcommunityhealth.org.au

Form received date:		Received by:	
UR #		Date responded:	