

Please ensure all sections of this form are completed in full and provide the required supporting documentation so your application can be processed.

Hospital(s) this request is for (e.g. Lakes):	
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Patient Details – person whose records are to be accessed			
Surname/Family Name		Given names:	
Date of Birth		NHI Number: (if known)	
Also known as/other/ previous names:			
Residential Address:			
Postal Address (if different):			
Mobile number:		Phone number:	
Email Address:			

Requestors Details – complete if requesting someone else’s records			
Requested by (full name):			
Relationship to Patient:			
Mobile number:		Phone number:	
Postal Address:			
Email Address:			

Basis for Request (select ONE):	Supporting Document(s) Required
<input type="checkbox"/> I am the patient requesting my own information	<input type="checkbox"/> Photo identity (for example, Driver Licence, Passport)
<input type="checkbox"/> I am the parent/legal guardian of the child who is under 16 years of age	<input type="checkbox"/> Photo identity (proof of relationship may be required) <input type="checkbox"/> Are there any current orders in place in relation to this child? If yes please provide us with a copy
<input type="checkbox"/> I have signed consent from the patient	<input type="checkbox"/> Photo identity (of Requestor) and signed consent by Patient Patient Signature: _____
<input type="checkbox"/> Other agency request with authorisation already collected/signed consent	<input type="checkbox"/> Copy of signed documentation authorising release of specified information, or consent signed by Patient Patient Signature: _____
<input type="checkbox"/> I have lawful authority over the patient’s affairs	<input type="checkbox"/> Photo identity and copy of lawful authority (for example, EPOA or PPR)
<input type="checkbox"/> I have authority as, or consent from, the Executor/Administrator of the deceased estate	<input type="checkbox"/> Photo identity and copy of relevant page from the Will or Letter of Administration.
<input type="checkbox"/> Other – please provide details:	

Signature of person who will be receiving the information			
Please read REQUESTING HEALTH INFORMATION FACT SHEET before signing form			
Name			
Signature		Date:	

Urgent Request – detail of why an urgent request is required	
DATE required by (ASAP not accepted):	
REASON for urgency*:	

*Every effort will be made to meet required timeframes, but this may not always be possible. In accordance with the Privacy Act 2020, we will respond to your request no later than 20 working days after date of receipt.

Date Range of Information Required	
<input type="checkbox"/> One admission/treatment (e.g. 1-10 June 2020) Admission Date:	<input type="checkbox"/> Date range (e.g. Feb to Jun 2020) Date Range:

Information Requested: select the categories of information required	
<input type="checkbox"/> Discharge Summary/Transfer of Care	<input type="checkbox"/> Mental Health and Addiction Records
<input type="checkbox"/> General Medical (Physical Health) Records	<input type="checkbox"/> Maternity Records
<input type="checkbox"/> Test results, e.g. Bloods, X-rays etc (please specify):	
<input type="checkbox"/> Other Information (please specify e.g. Bowel Screening):	

Delivery Details – please select ONE option	
<input type="checkbox"/> Courier to Requestors postal address (signature required)	<input type="checkbox"/> Collection from Clinical Records Department: <input type="checkbox"/> Patient is collecting <input type="checkbox"/> Other person collecting (must bring photo ID) Name of person:
<input type="checkbox"/> Post to Requestors postal address	
<input type="checkbox"/> Electronically	<input type="checkbox"/> View document (by appointment)

Returning Completed Form Options		
Please return this completed, signed form with supporting copies of required documentation to:		
BY POST <i>Clinical Records Team Leader Private Bag 3023, Rotorua 3046</i>	IN PERSON <i>Clinical Records, Te Whatu Ora, Lakes Rotorua Hospital, Corner of Arawa and Pukeroa Streets, Rotorua 3010</i>	BY EMAIL ClinicalRecords- RotoruaHospital@lakesdhb.govt.nz
If you need assistance or have questions relating to completing this request form, please contact Clinical Records on (07) 349 7793		

Office Use Only			
Date request received		Staff member who received	
Photo ID verified	<input type="checkbox"/> Yes	OR Security questions answered	<input type="checkbox"/> Yes
Form of ID used to verify			
Contact required before commencing process:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason if Yes:	
Name of staff member who compiled request:			
All documents checked to ensure are for correct patient:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Release Authorised by:		Date:	
Contact required before dispatch of documents:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason if Yes:	

Request declined:	<input type="checkbox"/> In Full <input type="checkbox"/> In Part	Decision made by:	
Reason:			
Requestor advised:	<input type="checkbox"/> By Phone <input type="checkbox"/> Health Records Counter <input type="checkbox"/> Email		

Information from your own health records, or on behalf of someone, can be requested from Te Whatu Ora. Please ensure all sections of the Release of Personal Health Information Request Form are completed, it has been signed appropriately, and the required supporting documents are supplied with your application. There is no charge for this service.

Requesting your own personal health information?

- 1 The request must be in writing by completing a Release of Personal Health Information Request Form.
- 2 Please include as much detail as possible regarding the information you require, including relevant dates. If you are specific about the information you want, we can respond more quickly to your request.
- 3 **All requests must be accompanied by proof of identification.** To protect the privacy of your personal information we need you to provide proof of your identity. Preferred identification includes a photo and signature (for example driver's licence or passport). If you are unable to provide this, please let us know as soon as possible so an alternative can be arranged.

Requesting health information for a child, relative, friend or deceased relative?

Additional proof will be required for the following requests.

- A Child: As above in 1-3.
PLUS - Proof of relationship to the child may be required, for example Birth Certificate.
Note: If the request is for a family member who is **not** a dependant (being a person up to and including 16 years of age) then consent from that person may be required.
- Relative or Friend: As above in 1-3.
PLUS - consent from the patient or a copy of the EPOA/PPPR (if applicable).
- Deceased Relative: As above in 1-3
PLUS - consent from the Executor/Administrator (if not self).
PLUS - a copy of the relevant page from the Will or Letter of Administration.
Note: If there is no Will, a decision on whether to provide access to the records will be made on a case-by-case basis.

How long does it take?

It may take up to 20 working days for us to respond to your request, however, all efforts are made to process all requests as quickly as possible. Incomplete applications may delay the processing of your request. If your request is urgent, you **must** provide a reason for the urgency and the timeframe within which you require the information, and all efforts will be made to meet this timeframe.

If we are unable to meet the 20 day timeframe, we will be in contact with you.

Declined Requests

In some circumstances we may refuse part, or all of a request for health information. We will let you know why. You do have the right of review of such a decision and can do this by contacting the Privacy Commissioner.

Retention and Disposal of Information

Under the Health (Retention of Health Information) Regulations 1996 and Public Records Act 2005, depending on the type of health information, the minimum retention period of health information could be 10 to 20 years from the day after the most recent date which an individual was provided services from a provider.

Once the required retention period has passed, rule 9 of the Health Information Privacy Code 2020 says that health information should be disposed of, securely, unless the health agency has a lawful purpose to retain it.

Correcting Information

If you think the information we have provided to you is inaccurate, you are entitled to ask for it to be corrected. Please contact the Clinical Records Team Leader at ClinicalRecords-RotoruaHospital@lakesdhb.govt.nz to further discuss this.

Need help with your request?

If you have any questions about any of the information above, please contact Clinical Records (07) 349 7793, or ClinicalRecords-RotoruaHospital@lakesdhb.govt.nz

Privacy Commissioner

Should you be dissatisfied with the information provided to you, a complaint can be raised with the Office of the Privacy Commissioner. Please visit their website <https://privacy.org.nz/your-rights/resolving-privacy-issues/> for more information.

This form and subsequent information are subject to the provisions of the Privacy Act 2020, Health Information Privacy Code 2020 and/or Official Information Act 1982.