APPENDIX 7

APPLICATION TO VIEW HEALTH INFORMATION

Name of Applicant: _____ Applicant's date of birth: _____

Applicant's address:

_____

Applicant's telephone number: _____ Email address:_____

I request to view:

My own health information: **NHI: _____**

OR The health information of another person:

Patient's name		
Patient's address		
Patient's date of birth		
Applicant's relationship to patient		
Specific health information sought (attach a separate sheet if necessary)		
Written authorisation attached?	Yes (√)	Document sighted (√)

If you are requesting information on behalf of another person, you must provide written authorisation, which may be in the form of a power of attorney, legal representation, guardianship, or representation of a deceased person's estate by an executor or administrator.

I accept full responsibility for the security of photocopies provided.

Patient's or Applicant's signature: _____ Date: _____

For Office use only

Applicant's proof of identity sighted	Driver's licence	
	Passport	
	Birth certificate	
	Other	
QGRC approval for release	Name:	Date:
Clinician notified	Yes	No
Appointment to view - date		
- time		
Copies required		

Staff signature: _____ Printed name: _____
Designation: _____ Date: _____