Health New Zealand
Te Whatu Ora

Patient Information

RELEASE FORM — Health Records

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:	
Email:	Telephone number:
Requestor's details - if different from above	
Name:	
Full residential address:	
Postal address:	
Email:	Telephone number:

INFORMATION REQUESTED		
General medical record - select the categories of information requested		
Date of admission / injury/medical treatment:		
☐ Emergency Department		
☐ Outpatient Clinic (e.g.includes reports from Doctors,Nurses and referrals from General Practitioners) Please 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)	☐ Mental Health Services	
☐ Other – please specify:		

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

Patient Information

RELEASE FORM Health Records

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 License)
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; and
- Someone who is clearly acting on behalf and in the best interests of a person who is unconscious and/or lacks capacity.

REQUESTOR'S AUTHORITY	
I am requesting my own information.	
Signature:	
Date:	

SUBMITTING COMPLETED FORM

Post completed form with all required attachments to:	
Post Patient Information Officer Health Records Wairarapa Hospital PO Box 96, Masterton 5840	**Email:** RES-PatientInfoReq@wairarapa.dhb.org.nz

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APPENDIX 1: REQUEST FOR A DECEASED PERSON'S INFORMATION

Health Records

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

In general, Health New Zealand – Wairarapa 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 they are 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.

A

I am the Executor /Administrator *(circle one)* **of**

. ..... who died .....

Print deceased person's name *Print year or date of death*

B

I authorise Health New Zealand - Wairarapa to release the information indicated on the "Request for Access to Health Information" form *(attached)* **to**

.....

Print name of person the information is to be released to

C

Name:	**Address:**
Signature:	
Telephone (home):	**Telephone (Mobile):**

D

☐	**I attach a copy of the Will/Letters of Administration** *(delete one)* **as proof that I am the deceased person's representative**
☐	**I attach a copy of photo ID as proof of my own identity**

The completed forms and all additional required attachments should be posted or emailed to Wairarapa Hospital.

Please note that where there is no Executor or Administrator, requests for a deceased person's information can be made in writing to Health New Zealand – Wairarapa's Privacy Officer under the Official Information Act 1982.

If you have any questions about this process, please contact the Privacy Officer.

This formandsubsequent information aresubject to theprovisions of the Privacy Act (2020), Health Information Privacy Code 1994 and/or Official Information Act 1982.

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