THE BAYS

REQUEST TO ACCESS A PATIENT RECORD

Return completed form to:
Health Information Manager
The Bays Hospital
PO Box 483
Mornington Victoria 3931

Patient's name: _____ Patient's date of birth: ____/____/____

1. Name of applicant: _____

*If the patient is incapable of giving or communicating consent, health information may be provided to a responsible person as defined by the Health Records Act 2001

2. What is your relationship to the patient?

☐ Self
☐ Parent
☐ Guardian
☐ Enduring Power of Attorney
☐ Medical Treatment Decision Maker under the Medical Treatment Planning & Decisions Act 2016
☐ Administrator under the Guardianship & Administration Act 2019

Please provide photocopied proof of authorisation to access patient information prior to this request being processed (e.g. Drivers Licence for self, Enduring power of attorney paperwork etc.)

3. Please outline the specific nature of information required, including admission date/s:

_____

_____

_____

4. Applicant's contact details:

a) Phone number(s): _____ (mobile) _____ (other)

b) Address: _____

_____ State _____ Postcode _____

5. Do you wish to receive a copy of the information or do you wish to view the information at the hospital? (Please tick relevant box)

☐ Receive a copy ☐ View information at the hospital

6. Please specify the preferred method of receiving a copy of the requested information:

☐ Express Post
☐ Collection (by the applicant: photographic identification will be required prior to release)

I acknowledge that in the event that I require an explanation of the record, or copies to be made, there may be costs involved and that payment would be required on or prior to release of information. I will be provided with an invoice which is to be paid prior to gaining access to the requested information.

Date: _____ Signature of applicant: _____