



**Chris O'Brien
Lifehouse**

**APPLICATION TO ACCESS LIFEHOUSE
PATIENT INFORMATION**

Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

AFFIX PATIENT LABEL HERE OR COMPLETE ALL DETAILS

INSTRUCTIONS

For release of information to non-health agencies, the following criteria must be met:

- the information required is for a purpose other than direct ongoing patient/client care (e.g. home modification)
- the client would not reasonably expect that their information will be disclosed to this service provider
- the service provider is a non-health provider (e.g. Centrelink, Meals on Wheels, Schools, Dept. of Housing etc.)

Consent is not required for disclosure of health information to health professionals for the purpose of ongoing care as per NSW Health Privacy Manual HPPs 10 and 11. This form is not to be used for Chapter 16A Child Protection requests.

CLIENT / PATIENT DETAILS

Surname: Title:
 Given Name(s): DOB:
 Residential Address:
 Telephone No. (H) (W) (M)
 E-Mail Address:

APPLICANT DETAILS (IF NOT CLIENT / PATIENT)

Organisation Name (if applicable):
 Contact/Applicant's Full Name:
 Organisation/Applicant Address:
 Telephone No. (H) (W) (M)
 E-Mail Address:
 Relationship to Client/Patient:

- If you are a parent/legal guardian, if there is a current custody/access order, please attach a copy of the order
- If you are requesting documents relating to the personal affairs of another person, on their behalf, they must give consent
Note: ID is required from both the patient/client and the applicant
- In the event that the person is deceased, the applicant must have consent of the executor/administrator of the deceased estate/authorised representative
- If you are the patient/client's legal guardian a copy of the guardianship order and/or relevant documentation is required
- Proof of relationship may be required in some circumstances

CONSENT

I authorise the Chris O'Brien Lifehouse to discuss with or release health information relating to the above-named client/patient to the following organisations/persons:

Organisations / Persons	Purpose of release of information	Information released

Signature: Date:
Client/Patient/Parent/Guardian

NB: Sensitive information

I understand that the information I authorise to be released may be classed as sensitive (according to 15.9 NSW Health Privacy Manual v2 and Section 17 Public Health Act 1991) and may include information related to HIV/AIDS, sexual assault, sexual health, drug & alcohol, aboriginal health, adoption, genetics and organ/tissue donor identification.

Interpreter Use Only

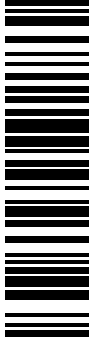
Interpreter Name: Interpreter's Signature:

Verbal consent (Staff Use Only)

Verbal consent should only be used where it is not practicable to obtain written consent. I have discussed the proposed request with the patient/client. I am satisfied that the patient/client understands the proposed uses and disclosures and has provided their informed consent to these.

Signature: Practitioner Name:

Designation: Date:



PAS001

Ver 1.0 Revised October 2014

PAS 001



**Chris O'Brien
Lifehouse**

**APPLICATION TO ACCESS LIFEHOUSE
PATIENT INFORMATION**

Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

AFFIX PATIENT LABEL HERE OR COMPLETE ALL DETAILS

PROOF OF IDENTIFICATION

Two forms of identification from the list below are required preferably photo ID and at least one with a signature.

Please tick the appropriate boxes to indicate the identification provided:

- | | | |
|---|--|--|
| <input type="checkbox"/> Medicare card | <input type="checkbox"/> Birth certificate | <input type="checkbox"/> Utility bill |
| <input type="checkbox"/> Current drivers license | <input type="checkbox"/> Passport | <input type="checkbox"/> Tertiary Education ID |
| <input type="checkbox"/> Pension/Health care card | <input type="checkbox"/> Credit/Debit card | <input type="checkbox"/> Employment ID |
| <input type="checkbox"/> Certificate of Citizenship | <input type="checkbox"/> Membership card (Union or trade, professional bodies, education institutions) | |
| <input type="checkbox"/> Other (specify) | | |

DETAILS OF REQUEST

We will inform you if fees are applicable for this request. Please tick the appropriate box to indicate the documents required:

INFORMATION REQUESTED	
<input type="checkbox"/> Viewing of medical records	
<input type="checkbox"/> Date of Attendance Letter	Date(s) required:
<input type="checkbox"/> Copy of medical records	Specify dates and documents required:
<input type="checkbox"/> Clinical Imaging / X-ray / Photography	Dates and details:
<input type="checkbox"/> Discharge Summary	Details required:
<input type="checkbox"/> Work Cover Certificate/Medical Certificate	Dates required:
<input type="checkbox"/> Medical Certificate or Cause of Death	Dates required:
<input type="checkbox"/> Medical Report	Details required:

- Please try to provide as much detail as you can to help us identify the documents you want
- We aim to process your request within 21 working days of receipt in the Health Information Services Department on the condition that the required information and fees have been received
- If information contained in the record is deemed to be sensitive, you may be asked to nominate a treating Healthcare Practitioner who will review the records with you

INFORMATION FOR APPLICANTS

Please send form to:

**Health Information Services
Chris O'Brien Lifehouse
PO Box M33 Missenden Road NSW 2050**

**Email: HIS@lh.org.au
F: +61 2 9383 1000
P: +61 2 8514 0909**

Office Use Only

Date Received: Proposed due date: Medicolegal Ref No:

Mode of provision Paper Electronic MRN: Date Completed:

ID obtained/sighted Yes No Processed by:

Mode of delivery Mail Pickup Email Fax