Request for access to health records

Applicant/Client Details

Given Name(s): _____ Surname: _____

Date of Birth: _____/_____/_____

Address: _____

Suburb: _____ Post code: _____

Telephone: (Mobile)_____ (Home/Work) _____

Records Required

Does this request relate to:

☐ **PART** of my health record (a service, treatment or appointment)   ☐ My **FULL** health record

If part of the record is required, please specify the part(s) of the record you require and indicate the dates (or best approximate) of the service: (*e.g. all information, notes only, include test results, referrals).*

_____

_____

_____

Reason for the request: *(e.g. transfer to a new clinic, seeing a specialist)*

_____

_____

_____

Office Use Only

Date received: _____   ☐ *ID confirmed*   ☐ *On Database*   ☐ *Client #(UR/Rec-Num):*_____

Service: ☐ *Dental*   ☐ *GP*   ☐ *Mental Health*   ☐ *AOD*   ☐ *Family Violence*   ☐ *NDIS*

☐ *Allied Health*   ☐ *RhED/Pathways*   ☐ *Other:* _____

If you are **NOT THE CLIENT** to whom this request relates, please complete the following section:

Given Name(s): _____ Surname: _____

Date of Birth: ____/____/_____

Address: _____

Suburb: _____ Post code: _____

Telephone: (Mobile)_____ (Home/Work) _____

Do you have the client's consent/authority to access her/his/their medical records?

☐ Yes (please attach written consent/authority*)   ☐ No

What is your relationship to the client? _____

If the application is for health records belonging to a client who is not the Applicant, the Applicant must present written consent from the client, or proof that the Applicant is the Executor of the Deceased Estate or other legal authority.

Signed: _____   **Date:** _____
          (Applicant's/Client's signature)

_____

All personal information collected, stored, used, released and destroyed by Star Health complies with the laws relating to confidentiality and privacy for both Victoria and Australia

Star Health may charge a fee for the work involved in providing access to documents you request (as allowed under legislation). This information will be provided when applicable, and prior to a request being processed.

Star Health will notify the Applicant/Client of a decision and/or provide copies of requested documentation as soon as practicable, within 30 days of receiving the completed request.

_____

Please **sign, date and return this form** with the required photo ID (eg current Driver's Licence, Passport or other documents (if applicable). You can return your request by:

Mail: Quality Manager   **Email:** Quality@starhealth.org.au
         Star Health
         PO Box 103   **In person:** Reception at any of our sites
         South Melbourne 3205