AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

SURNAME: _____ **NHI:** _____

FIRST NAMES: _____

DATE OF BIRTH: ____/____/____ **SEX:** _____

Please attach patient label here

Release of Information

All sections of this form must be completed or your application can not be processed

PATIENT DETAILS

Patient Hospital Number (NHI):

FAMILY NAME: **GIVEN NAME(S):**

PREVIOUS FAMILY NAME: ALSO KNOWN AS:

GENDER: Male / Female ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other _____

Date of Birth:

Residential Address:

Postal Address (if different from above):

Phone Number (Home): (Mobile):

REQUESTOR DETAILS

Requestor Name:

Postal Address:

PATIENT E-MAIL ADDRESS FOR RECEIPT OF CLINICAL CORRESPONDENCE

Please provide your e-mail address ONLY if you are happy for ADHB to use this method to send clinical correspondence to you, instead of via NZ Post. Please advise ADHB in writing immediately if your contact information changes. Please note: information may be less secure when sent via e-mail.

Patient Email Address for Receipt of Clinical Correspondence: _____

Phone Number (Home): (Mobile):

Relationship to Patient / Authority for requesting information:

REQUEST DETAILS

☐ View Record **OR** ☐ Receive Copies of documentation

Type of Information Required: ☐ Inpatient Information ☐ Outpatient Information

Approximate dates: _____

☐ Discharge Summary ☐ Clinic letters ☐ Radiology Report ☐ Latest correspondence

☐ Radiology CD ☐ Laboratory Report ☐ Complete copy of clinic record

Information will be from the following hospital:

☐ Green Lane ☐ National Women's ☐ Auckland ☐ Starship

☐ Mental Health – Facility name: _____ ☐ Other _____

Date Information Required: _____ Urgent? ☐ Yes ☐ No

If this request is **URGENT** please state reason:

Every effort will be made to meet the requested time frame, but this will not always be possible. In accordance with the Privacy Act 1993 40 (1), we will respond to your request no later than 20 working days after date of receipt.

INFORMATION DELIVERY DETAILS

☐ To be collected in person ☐ Standard Mail ☐ Courier Post

☐ Fax (only for urgent requests) ☐ Email (only if address supplied above)

Consent:

I confirm that the details provided above are true and accurate.

Requestor Signature: Date:

☐ ID Sighted Type of ID: Number:

Office Use Only

ROI Number: **Date Received:**

Information Sent:

☐ **File Viewed:** ☐ **Copies Given:** ☐ **Faxed:** ☐ **Email:** ☐ **Courier Post:** ☐ **Standard Mail:**

Date Completed: **Name:**

RELEASE OF INFORMATION

CR2645