Southern District Health Board
Piki Te Ora

Release of Health Information (District)

Date......../....../......   NHI...

Patient full name ....

[Also known as] ....

Residential address ....

Date of birth ..../....../.......   Contact phone: ....

E-mail*:.. ** Southern DHB does not recognise e-mail as always being a secure way of providing information and cannot take any responsibility for information that is accessed or received by others. If, however, you would like us to e-mail you the personal health information you have requested, please initial here _____.*

Health Record

Date of injury or medical treatment: ...../....../.....   Clinical record held at:

- ☐ Admission
- ☐ Emergency Department:
- ☐ Mental Health
- ☐ Outpatient clinic (specify)............................
- ☐ Other – please specify below:

Clinical record held at:

- Dunedin ☐
- Lakes ☐
- Southland ☐

Information Requested

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....

Patient Signature: ....   Date: ..../......../.........

Information to be sent by: Post ☐ E-mail ☐ Collect ☐ OK to leave message ☐

Proof of identity is required with all requests for patient information. If you are authorising another person to act as your agent, proof of your agent's and your own identity is required before Southern DHB can release information.

For Office Use Only

Form of ID: driver's licence / passport / other: ....ID verified: Yes ☐ No ☐

Request is authorised: Yes ☐ No ☐ State reason.................................. (**See attached**):

Information released to patient/agent ☐ Date of release ..../...../.............

Name and Signature of patient or agent receiving information...

Processed by staff: [sign] .... Date...../ ....../...........
File viewing appointment: [time] .... Date ...../....../ ....

Child under 16 years of age [legal guardian consent]:

Full name: .... Relationship to child: ....
Address: .... Daytime contact phone: ....

Is there a counsel for the child: Yes ☐ No ☐

If Yes name: .... Contact phone: ....
I certify that there are no protection orders issued in my name by the courts restricting access to any of the information held in the clinical record.

Signature: .... **Date:** ....

Consent by Patient Administration / Representative to Access Information:

Patient is deceased and I am the trustee / executor / administrator of the estate (copy attached).

I hold an active Enduring Power of Attorney relating to health and welfare (copy attached).

Name: .... Date: ....

Signature: .... Relationship to individual: ....

Address: .... Daytime contact phone: ....

Authorisation to Disclose Personal Information to a Third Party:

I... Signature: ....

Authorise that access be granted to the below named individual to view / have photocopies / collect the copy of the named individual's clinical record(s) indicated over the page.

Name of person released to: .... Relationship: ....

Address: .... Daytime contact phone: ....