

REQUEST FOR PATIENT INFORMATION

REQUESTING YOUR OWN INFORMATION

You will need to provide a copy of your identification, with photo and signature e.g. Drivers' Licence.
We may contact you if further verification is required.

PATIENT DETAILS

SURNAME:

FULL GIVEN NAME:

PREFERRED NAME:

FULL RESIDENTIAL ADDRESS:

DATE OF BIRTH:

NHI (IF KNOWN):

TELEPHONE NUMBER:

EMAIL ADDRESS:

INFORMATION REQUESTED

AMBULANCE CARE SUMMARY

111 CALL INFORMATION*

DATE(S) OF INCIDENT:

1.

2.

3.

LOCATION(S) OF INCIDENT:

1.

2.

3.

APPROX. TIME(S) OF INCIDENT:

1.

2.

3.

* If requesting the 111 call information, please provide the telephone number the 111 call(s) was made from, or advise if this is unknown. The caller's permission may be needed before this information is released to you.

1.

2.

3.

I confirm that I am requesting my own information.

SIGNATURE: _____

DATE: _____

Submit the completed form and all required attachments to:
Post: Wellington Free Ambulance, PO Box 601, Wellington 6140 or
Email: Improvement.team@wfa.org.nz or
Phone: 04 499 9909 if you would prefer to have this form posted to you.

This form and subsequent information are subject to the provisions of the Privacy Act 2020 and Health Information Privacy Code 2020. Your request will be acknowledged by Wellington Free Ambulance and a response will be sent to you within 20 working days.