WELLINGTON FREE AMBULANCE
kia ora te tangata

*We are the ones. 111*

# 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 1993 and Health Information Privacy Code 1994. Your request will be acknowledged by Wellington Free Ambulance and a response will be sent to you within 20 working days.