Patient Health Information

WELLINGTON FREE AMBULANCE
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Wellington Free Ambulance Clinical Services

REQUEST FOR PATIENT HEALTH INFORMATION FORM

(Option A) Patient details – records to be accessed

Surname/family name:	
Full given name:	
Full residential address:	
Date of Birth:	**NHI number:**
Telephone number:	

If you are a patient requesting a copy of your own information you are required to provide a copy of identification e.g. Drivers' Licence.

(Option B) Requestor's details – if different from above

Name:	
Full residential address:	
Postal address:	
Contact:	**Telephone number:**
Reason for request:	
Proof of representation / lawful authority *(see option B details overleaf)*	

INFORMATION REQUESTED

General medical record – select the categories of information

Date of call out/incident: / /
Location of incident:
Approx. time of incident:

BEFORE SUBMITTING YOUR FORM, PLEASE REFER TO THE REQUESTOR'S CHECKLIST

This form and subsequent information are subject to the provisions of the Privacy Act 1993 and Health Information Privacy Code 1994.
You will receive a response or acknowledgement within 20 working days.

REQUESTOR'S CHECKLIST

Option A

If you are a patient requesting a copy of your own health information:

- ☐ complete and sign the relevant section(s) on this form
- ☐ attach photo proof of ID (e.g. Drivers Licence)

Option B

If you are the representative * requesting the patient's health information

- ☐ complete and sign the relevant sections on this form
- ☐ attach evidence of representative status and/or lawful authority
- ☐ attach photo proof of your own ID to this form

Option C

If you are requesting a deceased patient's health information

- ☐ complete Appendix 1, attached to this form
- ☐ obtain authorisation, if necessary, from the deceased person's "representative"
- ☐ attach a copy of the completed/signed authorisation
- ☐ attach proof of your own and the representative's ID to this form

***Representative means:**

- **A parent or guardian of a child under 16 years of age**
- **The administrator or executor of the estate of a dead person (See option C above)**
- **Someone acting with lawful authority (such as a power of attorney) over a person's affairs**
- **Someone who is clearly acting on behalf of and in the best interests of a person who is unconscious and/or incapable**

REQUESTORS AUTHORITY

I am requesting my own information OR I am a representative requesting a patient's information *(delete one)*

Signature:

Date: / /

SUBMITTING COMPLETED FORM

Post completed form with all required attachments to:
Clinical Services
Wellington Free Ambulance
PO Box 601
Wellington 6140

Or scan and email to: ClinicalServices@wfa.org.nz

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APPENDIX 1: REQUEST FOR A DECEASED PERSON'S INFORMATION

Clinical Services

This form MUST be completed by the deceased person's "representative"
In general, Wellington Free Ambulance Board cannot release information about a deceased person unless it is being released to, or has been authorised by, the deceased person's "representative".
The term "representative" means the Executor or Administrator of the estate of a dead person.
The representative must also provide the following:

- A copy of the front page of the deceased person's "Will" or "Letters of Administration" as proof that s/he is the deceased person's representative; and
- Photo proof of the representative's identity (e.g. Drivers' Licence)*

* This is not required where the representative is either acting in their professional capacity as a Barrister & Solicitor of the High Court of New Zealand or Trustee Corporation.

A

I am the Executor OR Administrator *(delete one)* **of**

……who died……

Print deceased person's name — Print date of death

B

I authorise Wellington Free Ambulance to release the information indicated on the "Request for Health Information" form (attached) to:

……

Print name of person the information is to be released to

C

Name:	**Address:**
Signature:	
Telephone (home):	**Telephone (mobile):**

D

☐ **I attach a copy of the will/Letters of Administration** *(delete one)* **as proof that I am the deceased person's representative.**

☐ **I attach a copy of photo ID as proof of my own identity.**

The completed forms and all additional required attachments should be posted or scanned and emailed to Clinical services at Wellington Free Ambulance: ClinicalServices@wfa.org.nz
If you have any questions about this process, please contact: ClinicalServices@wfa.org.nz

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You will receive a response or acknowledgement within 20 working days.