Health
Western NSW
Local Health District

APPLICATION / CONSENT TO RELEASE CLINICAL NOTES/HEALTH INFORMATION

Patient/Client Details to whom the records relate:

Surname:	First Name:	
Date of Birth:	Previous Names:	
Current Address:		
Address at time of treatment:		
Home phone:	Mobile:	Work:

Are you the patient/client? □ **Yes**
□ **No -** state your relationship to the patient:_____

Applicant's Surname:	First Name:	
Current Address:		
Home phone:	Mobile:	Work:

Type of Access Required: (please tick appropriate box)
□ Copies of documents □ View records only at facility

State specific information you require – includes dates or approximate dates of attendance:

Held at which health facility?

State purpose for which you require the information:

Identification Required: 2 forms of identification that contain a signature only **OR**
1 form of identification that contains a photo and signature

Fees: **$33.00** for copy of notes plus **40 cents per page** when over 80 pages

Signature of Applicant:_____ **Date**_____

Office Use only:
Date Received:_____ Fees Paid? □ In full □ Partial □ No Date
entered onto register:_____ ID Sighted: □ Yes □ No
Copies of ID destroyed? □ Yes □ No Signature: _____

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