REQUEST FOR HEALTH INFORMATION

Sexual Wellbeing Aotearoa

PART 1 *– Please complete relevant sections*

CLIENT DETAILS			
Surname/Family Name			
Given Names			
Previous Family Name		Also Known As	
Residential Address			
Postal Address (if different)			
Contact Number	( )	Mobile Number	( )
Email Address			
Date of Birth	/ /	NHI (if known)	
Date information required by (if not urgent)	/ /	Is this information urgent? ☐ Yes ☐ No	

INFORMATION REQUESTED		
What Clinic did you visit?		
Record/Result	**Request relates to:**	**Date**
☐ Result or ☐ Health Record		/ /
☐ Result or ☐ Health Record		/ /
☐ Result or ☐ Health Record		/ /

HOW DO YOU WANT TO RECEIVE THE INFORMATION	
☐ I will collect it in person	☐ Other (please specify)
☐ Send it electronically to my GP	GP Details
☐ Email (to select this option you **must** sign the acknowledgement on section E of this form)	

PART 2 *– Please complete only relevant sections*

A. CONSENT BY INDIVIDUAL TO ACCESS OWN INFORMATION			
I	Request access to my health information as outlined in Part 1 of this form.		
Signature		Date	/ /
☐ I have attached proof of my ID			

Please also complete all relevant sections of PART 2 on the following page.

SEXUAL WELLBEING AOTEAROA USE ONLY			
ID Verified ☐ Yes ☐ No	Form of ID ☐ Drivers Licence ☐ Passport ☐ Other		
Request is authorised ☐ Yes ☐ No	Specify reason if not authorised		
Date Information Released / /			
Name of person receiving information			
Name of staff member processing request		Date	/ /

PART 2 *– Please complete only relevant sections (continued)*

B. THIRD PARTY ACCESS REQUESTS			
I *(Clients full name)*	Request and consent to the following person receiving my health information as outlined in Part 1 of this form.		
Third Party Details			
Full Name of person			
Residential Address			
Contact Number	**( )**		
Third Party Signature		Date	/ /
I authorise that access be granted to the above named individual to view/have photocopies/collect the copy of the named individual's Clinic Record (s) as indicated Part 1 of this document.			
Client Signature		Date	/ /
☐ The third party who is to receive my information has completed this section ☐ I have attached proof of ID for myself as the client ☐ I have attached proof of ID for the third party who is to receive my information			

C. CONSENT BY CHILD'S LEGAL GUARDIAN OR NEW ZEALAND COURT APPOINTED GUARDIAN, **TO ACCESS INFORMATION IF UNDER 16 YEARS OF AGE**			
Name		Relationship to Individual	
Address			
Is there a Counsel for the Child	☐ Yes ☐ No		
If Yes - Name:		Contact Number	
I certify that there are no Protection Orders issued in my name by the courts restricting access to any of the information held as health information records. I request access to the child's health information as outlined in Part 1 of this form.			
Signature		Date	/ /
☐ I have attached proof of my ID ☐ I have attached proof of guardianship			

D. CONSENT BY INDIVIDUALS ADMINISTRATOR/REPRESENTATIVE TO ACCESS INFORMATION			
☐ I hold an enduring Power of Attorney relating to health for the client in Part 1 of this form. ☐ The individual is deceased and I am the Trustee/Executor/Administrator of the Estate for the client in Part 1			
Name		Relationship to Individual	
Signature		Date	/ /

E. CONSENT FOR EMAIL RECEIPT OF INFORMATION			
It is possible for emails to be accessed or viewed by another computer/internet user without your knowledge or permission. If you wish to keep your health information strictly private, we advise against consenting to receive via email. If you are requesting that your information be sent to you or another person by email, you acknowledge and agree to the risks of transmitting and receiving your information by email and do not hold Sexual Wellbeing Aotearoa liable for any privacy breach that may occur - by signing below.			
Signature		Date	/ /
REQUESTERS EMAIL ADDRESS FOR RECEIPT OF HEALTH INFORMATION Please provide your email address below ONLY if you want to receive records via email			
Email Address			

Health Information Requests

Please read the following information before completing the authorisation form.

Principle 6 of the Privacy Act 2020/Health Information Privacy Code 2020 states that people have a right to ask for access to their own personal and health information. Generally, Sexual Wellbeing Aotearoa must provide access to the personal and health information that we hold about someone, if the person in question asks to see it.

People can only ask for information about themselves. The Privacy Act does not allow others to request information about another person, unless they are acting on that person's behalf and **have written permission**. You must there for personally identify yourself as the person signing the request form and proof of identity must be attached.

PLEASE NOTE Proof of identity is required with **ALL** requests for client information. If you are a client authorising another person to act as your representative, proof of your representatives and your own identity is required **before** Sexual Wellbeing Aotearoa can release information. Proof **must** be attached for deceased and child protection/custody order or guardianship.

Sexual Wellbeing Aotearoa will accept the following as proof of identity: Drivers Licence or valid passport. If unable to produce a Drivers Licence or Passport TWO other forms of ID will be required e.g Community Services Card, birth certificate

If you wish to view your clinical records, you can but it must be under supervision and you must not alter, deface or remove any information. You may seek a correction of that information by writing to the Quality & Compliance Advisor at Sexual Wellbeing Aotearoa.

Under the Privacy Act 2020, we will respond to your request within 20 working days. Copies of health information are free of charge.

Sexual Wellbeing Aotearoa may refuse you access or disclosure of certain parts of your clinical record under the provision of the Health Information Privacy Code 2020. We will state the reason for such a refusal and you do have the right of review of the decision through the Privacy Commissioner.

Clinical information regarding a deceased person will only be released with the written consent of the Executor or Administrator of the deceased estate. If you are the Executor or Administrator, please provide us with a copy of the relevant documentation as this will help us process your request.

Please return the completed form and required identification documents by:

Mail	Deliver	Email
Quality Compliance Advisor Sexual Wellbeing Aotearoa National Office Level 2/205 Victoria Street Te Aro Wellington	Dropping into your nearest Sexual Wellbeing Aotearoa Clinic	Quality@sexualwellbeing.org.nz