CANOPY CANCER CARE

Request for release of medical information

To obtain patient information from Canopy Cancer Care please complete the following request form.

PLEASE NOTE

To ensure privacy and protection of clinical information, requests will only be actioned on receipt of a completed request form, with the accepted proof of ID and authorisation.

Patient details – records to be accessed	
Surname/Family Name:	
Full given Names:	
Date of Birth:	NHI Number:
Full residential address:	
Home number:	Mobile Number:

Requestor's Details – if different from above	
Surname/Family Name:	
Full given Names:	
Date of Birth:	
Full residential address:	
Home Number	Mobile Number:
Email Address	

- **If you are requesting information that is not your own you need signed authority from the patient concerned and provide proof of your identity**.
- **Clinical information regarding a deceased patient will ONLY be disclosed to the deceased patient's legally appointed representative.**

Proof of identity

Proof of identity required, for **ALL** types of access.

The following documents are acceptable as proof of identity;

Driving licence

Passport

Birth certificate

Consent

1 - INDIVIDUAL PATIENT REQUEST FOR COPY OF OWN CLINICAL NOTES	
I wish to receive copies of my clinical records. I have attached a copy of my identification.	
Signature:	Date:

2 -REPRESENTATIVE REQUEST FOR COPY OF PATIENT'S CLINICAL NOTES AUTHORISATION *(On behalf of another person)*	
I hereby authorise Canopy Cancer Care to release my clinical records to; …….. *(Enter the name of the person acting on your behalf)* To whom I have given my consent to act on my behalf I have attached a copy of my identification. I have attached a copy of my representative's identification.	
Signature:	Date:

3 -REQUEST FOR A COPY OF A DECEASED PATIENT’S CLINICAL NOTES	
I am the deceased patient’s legally appointed representative I have attached confirmation of my appointment (Grant of Probate, Letter of Administration, Power of Attorney or the patient’s Will). I have also attached my identification.	
Signature:	Date:

Post completed form with all required attachments to: Emma Moore, Clinical Services Manager, Canopy Cancer Care, 98 Mountain Rd, Epsom, Auckland, 1023

OR E-mail to: privacy@canopyhealthcaregroup.co.nz

The turnaround time for processing this request is 5 working days from receipt of the completed form and supporting documentation. The requested information will be emailed to you.

***Please tick to confirm that you are happy to have the requested information emailed directly to you** ☐