CAMBRIDGE
MEDICAL CENTRE

Email: info@cambmedcentre.co.nz

REQUEST FOR MEDICAL RECORDS

RE: Full Name:

DOB:

NHI :

Privacy legislation states that the practice has 20 working days to respond to your request. Please advise how you would like to receive your medical records: ☐ via Email ☐ to collect printed hard copy

Your email address:

Please note if you are receiving your records via email we require you to email a copy of your ***photo ID, e.g. passport or drivers license***. We will only **email ten years worth** of medical records. The records will be password protected and emailed in multiple file attachments due to their size.

If you or your representative will be picking up the medical records you will need to ***show photo ID e.g. passport or drivers license***. If a representative is requesting medical records on your behalf, there will need to be a signed authority from the patient that they are able to do so.

Please supply me with the following information:

1. All medical information from my file (ten years worth if via email)

2. Medical information on my file relating to the following treatment, condition or dates:

_____

3. Other :

_____

3. I do not wish to disclose the following:

_____

Declaration : I understand in signing this request that my documentation will be made available to either myself or my representative with my consent. I am aware by naming a representative person that disclosure will follow. ***I understand that representative is a parent/guardian of a child, trustee of deceased, welfare guardian - court appointed, power of attorney.***

No sensitive information will be disclosed without patient approval first. By signing this declaration I am approving that disclosure of sensitive information, unless I have stated above what sensitive information, should not be disclosed.

Signed : _____ Name : _____

Date : _____ D/L number: _____

OFFICE USE

Received by : _____

Signed : _____

Date: _____