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| **CLIENT REQUEST TO ACCESS OWN HEALTH RECORDS** |
| BCHS clients must complete this form if they would like to request access to their own health records held by BCHS. BCHS will respond to these requests under the requirements of the Health Records Act 2001 (Vic). |
| **Client Details:** |
| Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Information Requested:** |
| Please describe in as much detail as possible the health information that you would like BCHS to provide you access to (including information for specific services/programs, types of health information and the date range for the information requested).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date range: From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Preferred Method of Access (please tick ONLY one):** |
| ☐ By attending in person and having the health information explained to me by a BCHS service provider☐ By attending in person and inspecting the health information with the opportunity to  take notes☐ By receiving a printed copy of the health information☐ By receiving a digital copy of the health information (via e-mail or CD) |

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| If you have selected to receive a copy of the health information, please tick ONLY one option:☐ I will collect the copy of the health information from BCHS.  BCHS site you would like to collect the health information from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ I would like the copy of the health information posted to me at the address listed above.☐ I would like the copy of the health information e-mailed to me at the e-mail address listed above.*Please note that you will be required to provide a legible copy of your photo identity (e.g. Driver’s Licence or Passport) before a copy of the health information is provided to you.* |
| Please note that requests to access health records are generally considered non-urgent and will be prioritised for action against other urgent client information requests. This request will be actioned within the timeframes specified under the Health Records Act 2001 (Vic). Please ensure that all requested information is completed in order for this request to be actioned in a timely manner. |
| **Client or Authorised Representative Consent:** |
| I, (Print Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Authorise the release of my own health information as detailed above.☐ Am the authorised representative for the above client and authorise the release of their health information as detailed above.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email outlinePlease submit the completed request form to:inforequests@bchs.com.au **OR**Mailbox outlineRisk, Quality and Compliance TeamBendigo Community Health Services PO Box 1121,  Bendigo Central VIC 3552 |