Your Health Information

The Southern Cochlear Implant Programme takes great care to ensure the privacy of your health information is respected.

The Southern Cochlear Implant Programme collects information about you and your health to provide you with appropriate care, to keep you and others safe, to plan for and fund health services, to carry out teaching and research, and for statistical purposes. This information is shared with others involved in your health care within our organisation.

Be assured that your information is kept secure. Only authorised persons have access to your information. This may include other agencies, where authorised by law.

Accessing your Health Information

If you are or have been a patient/client of the Southern Cochlear Implant Programme you have a right to ask for and be given access to your personal health information. This will generally be provided as photocopies of your health records.

If you wish to obtain your health records, please fill in the form: "**Request for Access to Personal Information"**

The form has various sections:

- individual patient request for copy of own clinical notes
- parent/guardian request for copy of child(ren's) clinical notes
- representative request for copy of patient's clinical notes
- If your request is for information from a deceased person's clinical notes then you will also require personal representative authorisation to enable release of a copy of a deceased person's clinical notes

The more specific you are about the information you want (e.g. notes from a particular admission in hospital or test results), the quicker we can respond to your request.

We require some form of identification so we can be sure that we are sending it to the correct person. A copy of your driver's licence, birth certificate or similar is required. Requests received electronically still need to provide some form of identification.

If you prefer to send us a letter, please be sure to include the following:

- your full name (and any other names you have been known by)
- your date of birth
- your National Health Index (NHI) number if known
- the information you are requesting
- contact details in case we need to query anything
- proof of identity
- anything else that may assist us to deal with your request.

Correspondence should be sent to Southern Cochlear Implant Programme, Block 1, Milford Chambers, St. George's Hospital, 249 Papanui Road, Christchurch 8014

We have 20 working days to indicate to you if we will action your request. We can refuse your request, but only for very limited reasons which we would explain at the time.

In most cases we should be able to provide you with the information within 20 working days. If your request is urgent please state the reasons why the request is urgent and we will do our best to assist.

Sometimes we may contact you if there is a lot of information available to ensure that we supply what you need. Where there is a lot of information to be provided we may not be able to supply it all within the 20 working days – but we will certainly inform you that we are dealing with your request.

There is no charge for the provision of this information.

Correcting information

If you think that the information we hold is inaccurate, you are entitled to ask for it to be corrected. Apart from simple factual information (such as your name, date of birth, ethnicity) you may be invited to provide a statement of the correction sought. This statement will be attached to your file.

Southern Cochlear Implant Programme
Block 1, Milford Chambers
St. George's Hospital
249 Papanui Road
Christchurch 8014
Phone: (03) 355 3041
Fax: (03) 355 3045
reception@scip.co.nz

REQUEST FOR ACCESS TO PERSONAL INFORMATION

Surname/Family Name: *(Name on Record(s) to release)*	______
Full Christian Names:	______
Date of Birth: ______	Phone Number: ______
Full Residential Address: or Postal Address	______ ______
NHI Number *(if known)*	______
Requestor's Name: **(If different from above)**	______
Full Residential Address: **(If different from above)**	______

Please indicate the Service you require information from and the date(s) applicable. If you require a complete copy for that Service, please indicate so.

❑ AUDIOLOGY RECORD ______

❑ HABILITATION / REHABILITATION RECORD ______

OFFICE USE ONLY:

IDENTIFICATION SIGHTED BY: ______________________

____

FORM OF IDENTIFICATION WAS: ______________________

____

APPROVED FOR RELEASE BY: ______________________ General Manager ______ Date

AUTHORISED CONSENT TO ACCESS PERSONAL INFORMATION

Highlighted sections to be completed AND please read Checklist before posting

CONSENT BY INDIVIDUAL TO ACCESS OWN INFORMATION

Signature: ………………………………………………………..……… Date: ………………………………………..

CONSENT BY INDIVIDUAL'S PARENT / GUARDIAN TO ACCESS INFORMATION

Signature: ………………………………………………………..……… Date: ………………………………………..
(Please read statement below when signing)

Relationship to Individual: ……………………………………………………………………………………………

IMPORTANT: *In signing, I certify there is no* ***Protection Order*** *issued in my name, by the Courts, restricting access, to the individuals named in this consent form, to release personal information.*

CONSENT BY INDIVIDUAL'S REPRESENTATIVE TO ACCESS INFORMATION

Signature: ………………………………………………………..……… Date: ………………………………………..

Relationship to Individual: ……………………………………………………………………………………………

Note: *Proof will be required in the form of an "Enduring Power of Attorney / Welfare Guardian"* ***or*** *if individual deceased, copy of their Will stating person signing is the Executor. In lieu of no Will, "Letters of Administration" will be required.*

AUTHORISATION TO DISCLOSE PERSONAL INFORMATION TO A THIRD PARTY

I, ……………………………………………………………………… Signature: ……………………………………

Authorise that access be granted to the below named individual to view and or photocopy the named individual's clinical record(s) indicated over the page.

Name of person released to: ……………………………………………………………………………………….

The relevant consent box above must also be signed before disclosure to third party actioned

REQUESTOR'S CHECKLIST

❑ Please ensure you have signed the appropriate section(s) above and enclosed copies of relevant identification.

❑ When signing the appropriate section, ensure that relevant copies of "Enduring Power of Attorney/ Welfare Guardian" **or** the Will **or** "Letters of Administration" are enclosed.

❑ **Post completed form**, with relevant copies of Identification, to address over page.

Note: *This form and subsequent information are subject to the provisions of the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982. You will receive a reply within 20 working days unless deemed urgent. Further information is available from the Office of the Privacy Commissioner 0800-803-909 or www.privacy.org.nz.*