

INFORMATION REQUEST FORM (PATIENTS)

I wish to have access to my information:

☐

I wish to grant access to my information to:

☐

Name : _____ relationship to patient: _____

Full Name _____

NHI/HCU Number _____

Please list any previous/maiden names _____

Address _____

Phone Number _____ Cellphone Number _____

Date of Birth _____

Admission date _____ Discharge date _____

Information Type: Invoice ☐ Receipt ☐ Clinical Record (full copy) ☐

Clinical Record Specific Form ☐ Please state _____

Comments: _____

Signed _____ Date _____

Proof of Identity sited: YES ☐ NO ☐ Sited By: _____
(if required)

Collected ☐

ID Type (drivers licence/passport/other) _____
(or attach copy)