ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

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 icence/passport/other)____
(*or attach copy*)

Fax: 355 9175 Email:clinical.records@stgeorges.org.nz (clinical) sjw@stgeorges.org.nz (financial)