# 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 sighted: yes no Sighted By:

 ID type (drivers’ license/passport/other)

 (*or attach copy*)

##  Collect Couriered email (address)…………………………………………………………

 **Where applicable proof of relevant power of attorney must be obtained (please attach copy)**

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