AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai
Mental Health Services

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: ___/___/___ SEX: _____

Please attach patient label here

Authorisation / Request to Access Clinical Records

I _____

A Service User of _____, Mental Health Services,

Auckland District Health Board, hereby give authority for my lawyer

_____

to have access to all my medical certificates, clinical and other records relating to me.

Under Rule 11, Section 1(b)(i) (Health Information Privacy Code 1994)

_____

Service User's Signature Date

_____

Actioned by RN / Doctor Print Name Date

PLEASE SEND TO MEDICAL RECORDS TO BE FILED IN THE LEGAL FILE

AUTHORISATION/REQUEST TO ACCESS CLINICAL RECORDS