Bethesda health care

Appendix 7.2

Bethesda Hospital

Application to AMEND Patient Information

RETURN TO: Health information Manager
PO Box 45
CLAREMONT
WESTERN AUSTRALIA 6910 Ph: 9340 6300

SECTION 1: Applicant Details

Name of Patient: **Date Requested:**

Name of Applicant: .....

(If not patient, tick below relationship to patient, ie. Guardian, Parent, Power of Attorney etc)

☐ **Parent**	☐ **Spouse or Defacto**
☐ **Child or Sibling > 18 years**	☐ **Relative > 18 years and member of patients household**
☐ **Guardian**	☐ **Enduring Power of Attorney**
☐ **Intimate personal relationship with patient**	☐ **Person nominated by patient to be contacted in case of emergency**
Address:	**Post Code:**

Contact Phone Number(s):	**Business Hours:**	**After Hours:**
Date of Birth:	**Medical Record No:**	**Admission No:**

Signature: ..... Date : ...../...../.....

SECTION 2: Amendment Details

Please specify the exact amendment and reasons for the amendment that you wish to have noted on the hospital patient record

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Signature: ..... Date: ...../...../.....

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SECTION 3: Amendment Denied - Details:

If request to amend the record is denied, please state reasons for denial:

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Name *(please print)* .....

Signature: ..... Date: ..../..../....

Requestor notified of decision and reasons ☐ **YES** ☐ **NO**

Name *(please print)* .....

Signature: ..... Date: ..../..../....

SECTION 4: Hospital Verification

BETHESDA Private Hospital undertakes to ensure that this amendment will be filed with the Hospital Patient Records.

Verification of Patient or Authorised Person Identity: ☐ **YES** ☐ **NO**

I.D sighted, copied and certified

(Please Tick type)

- ○ Photo ID
- ○ Drivers licence
- ○ Credit card
- ○ Guardianship order
- ○ Enduring power of attorney
- ○ Other *(please specify)*
- ○ Passport

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Signed on behalf of		
..... Name and Position:	..... Department:	..... Signature: