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

Signature: Date: / /

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SECTION 3: Amendment Denied - Details:

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

Name *(please print)*

Signature: Date: / /

Requestor noti“ ed 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 “ led with the Hospital Patient Records.

Veri“ cation of Patient or Authorised Person Identity: YES NO

I.D sighted, copied and certi“ ed

(Please Tick type)

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

Signed on behalf of

Name and Position: Department: Signature: