Appendix 9.3

ARMADALE MENTAL HEALTH SERVICE

REQUEST TO ACCESS DOCUMENTS (Mental Health Act 2014)

Consumer's Surname Name: ________________ **Consumer's Given Names:** ________________

Postal Address: ____ Postcode:_________

Phone: Hm: ____________Wk: _________ Mb: ________ Date of Birth: ___/___/____

Applicant Details: As Above ☐ Nominated Person ☐

Surname Name: ___________________ **Applicant's Given Names:** ___________________

Postal Address: ____Postcode: ______

Phone: Hm: ____________Wk: _________ Mb: ________ Date of Birth: ___/___/____

Relationship to patient: Spouse ☐ Parent ☐ Guardian ☐ Son/Daughter ☐ Other ☐ (Please specify):
__________________________ Proof of guardianship: ☐

DETAILS OF REQUEST:

I am applying for access to document(s) pertaining to: (*include relevant date/s of contact with service and treatment details*)

FORM OF ACCESS: *(Please tick one)*

I wish to inspect the document(s) ☐

I require a copy of the document(s) ☐

I require access in another form ☐

I would prefer to have the documentation: *(Please tick one)*

Posted to above address: ☐

Personally collected on ___/___/____

My record to be collected by ____

I authorise the person nominated above to collect my medical records on my behalf: ☐

APPLICANT'S SIGNATURE: ________________________________ **DATE:** ___/___/___

Please send to: Service Director Mental Health, Armadale Health Service, PO BOX 460 Armadale WA 6992

(Office Use Only)
UMRN: ________________________ Psychiatrist (If active): _____________________
Application received on: ___/___/___ Acknowledgement sent: ___/___/___
Deadline for response: ___/___/___
Proof of Identity (If required): Driver's License ☐ Passport: ☐ Medicare: ☐ Birth Certificate ☐
Signed: ____________ Print:_____________ Designation:_____________ Date:___/___/___