Records and paperwork at hospital

Summary

- There are a number of forms you are required to fill out for every hospital visit.
- You will need to provide information such as your personal details, Medicare card and other health information to the hospital.
- Your health record is the document that details your medical history and medical care over a period of time.
- Hospital staff members keep up-to-date health records of all patients.
- You have a right to access your health records.
- You may authorise family members or third parties to access your health records and make decisions on your behalf.

For your medical team to effectively treat you during and after your hospital stay, an up-to-date health record (also called a medical record) should be maintained by hospital staff at all times. This information helps medical staff work out what treatment is most suitable, and they can use it to track how you are responding to the treatment. You may also need to fill out forms and provide other information at various times during your hospital stay.

By law, all hospitals and healthcare providers must follow strict privacy guidelines when managing your health records.

Paperwork to bring to hospital

Before you go to hospital, it is a good idea to make sure you have all the paperwork and identification information you need. Different members of the medical and administrative teams will require different documents. Keep it all in one place so it is easy to find.

When you go to hospital, you will need to bring your:

- personal information, such as next-of-kin details
- Medicare card
- funding details (for example, private health insurance, WorkCover)
- pharmacy or government entitlement discount cards
- list of your current medication and dosage
- specialist's contact details
- completed admissions forms (non-emergency)
- current test results, such as x-rays, scans and pathology.

Paperwork during your hospital stay

There is a lot of paperwork required to help keep track of your journey through the hospital system. When doctors, nurses, administration staff and other healthcare professionals see you, they need to know what stage you are at with your diagnosis, treatment or recovery.

During your hospital visit, you may need to complete:

- an admission form in the emergency department
- an outpatient admission form
- an in-patient admission form (for an overnight stay)
- a consent to treatment form
- a discharge form

- a power of attorney form.

Your health records

Keeping accurate health records is an important part of providing medical services. It helps medical staff with their diagnostic and medical decisions.

Your health record is the document that details your medical history and medical care over a period of time. Doctors, nurses and other health professionals make notes in your health record on everything from illnesses, symptoms and the results of medical tests to the types of medication that have been prescribed to you.

Accessing your health records

Whether you are at a public or a private hospital, you are permitted by law to access your health record. You may request a copy, choose to view the original or, in certain circumstances, receive a summary.

To request access, you must complete a health record access form and provide photo identification. There are costs involved when accessing your records and these vary from hospital to hospital. Check with your hospital to find out the details. Applications for information may take up to 45 days to be processed.

Permission for others to access your health records

Hospitals are required by law to protect the privacy of your medical information. The information relating to your healthcare may be used by the healthcare professionals working at the hospital and also by those assisting in your treatment after you leave hospital. Hospitals are required to keep your records on file. This ensures they can be accessed at a later date by your doctor or healthcare provider, in case you need further treatment.

Information will only be provided to a third party if you provide written authority for them to access your records. If you have given someone power of attorney over all of your affairs, they may also access your health records.

Researchers may sometimes use your information for research purposes and public health initiatives. In most cases, the information is de-identified (meaning that your personal details have been removed).

Speak to a member of your healthcare team if you have concerns about how your information is being shared. For more information on the privacy of your medical information, visit the **Confidentiality and privacy in healthcare** page.

Carers and health records

Carers play an important role in the treatment and recovery process. However, they will only be able to access your health records if you provide written authorisation for them to do so.

Hospital staff members are not authorised to provide specific information about your condition or treatment over the phone to anyone. It is important to include your carer in all discussions with your doctor, so they are aware of your situation.

Where to get help

- Your doctor (GP)
- Your hospital
- Hospital staff

This page has been produced in consultation with and approved by:

Department of Health and Human Services