Shared Digital Health Record opt out or opt in request form

Purpose of this form

Use this form to request to:

- Opt out of the Shared Digital Health Record (restrict all access to your health information).
- Opt back in to the Shared Digital Health Record (provide access to your health information).

Completing this form for a dependant

Parents or legal guardians can make participation choices for children in their care (aged under 16 years), or for dependant adults unable to decide due to illness or incapacity.

Proof you are able to act on behalf of a dependant is required, such as:

- birth certificate for a child
- enduring power of attorney for an adult.

Returning this form

Before returning this form, make sure you have:

- answered all required questions
- signed and dated the form
- attached or enclosed copies of your photo identification and any other required documents.

Email your completed form to **customerservice@health.govt.nz** or post to:

HNZ Customer Service Team
Health New Zealand
Private Bag 3015
Whanganui Mail Centre
Whanganui 4540

For more information

Go to **https://info.health.nz/SDHR** or email **customerservice@health.govt.nz**

About the Shared Digital Health Record

We're expanding the information available in the systems your doctors and other healthcare providers use, so they have your health information no matter where you are in Aotearoa New Zealand. This will help them give you the best treatment and care, where and when you need it.

We're doing this through a new health information connector called the Shared Digital Health Record, which allows your important health information to be securely available to your healthcare providers.

Sharing of health information is already happening in some regions and healthcare settings. The Shared Digital Health Record will help this sharing to take place consistently across the country, so your health information can follow you wherever you go.

What information will be shared?

Health information about you that will be securely shared includes your:

- Allergies and intolerances - for example, an allergy to penicillin.
- Your medical conditions, such as asthma, diabetes and long-term conditions.
- Your vital signs like your temperature, heart rate and blood pressure.

Other information may be shared in the future - see our website for details: **https://info.health.nz/SDHR**

The Shared Digital Health Record will collect and share health information held in your general practice's IT system. Other health information - such as immunisations and medicines - will be accessed from national databases if shared in the future.

You can opt out from sharing your health information

You can opt out of sharing your health information through the Shared Digital Health Record information connector. This means some healthcare providers may not have access to your health information unless you are able to tell them - including in emergencies. This could affect the speed and safety of the care you receive.

If you choose to opt out, your GP will still hold your health information, and you can continue to receive care as usual from healthcare providers. Any existing information in the Shared Digitial Health Record will be archived and cannot be viewed by other healthcare professionals treating you.

If you opt out of the Shared Digital Health Record, you may still be contacted about information sharing through other health services, such as immunisations.

You can opt back in to sharing your health information

You can choose to opt back in to the Shared Digital Health Record at any time. There may be a delay before your sharing settings are updated. Your health record may be incomplete, because Health NZ can’t retrieve past data from some healthcare providers, like urgent care or telehealth.

If you have also asked your healthcare provider to opt you out of the Shared Digital Health Record health connector, you will also need to ask them to opt you back in.

Please complete if you are requesting to opt out or opt back in to the Shared Digital Health Record information connector

Your details

To opt out or opt back in, please provide the following details, including a photo identification (see 'Supporting documents required' section later). Requests to opt out of or opt back into the Shared Digital Health Record may take up to five working days to be processed.

Given name(s): _____

Family name: _____

Date of birth: ____ / ____ / ____ NHI number (if known): _____

Alternative names known by (if any): _____

Physical address: _____

Provide at least one of the following contact methods

Phone number: _____ Email: _____

Mailing address (if different to above): _____

Reason for completing this form (tick all that apply)

☐ I am opting out of the Shared Digital Health Record

☐ I am opting out of the Shared Digital Health Record for my children or other dependants

☐ I am opting back in to the Shared Digital Health Record

☐ I am opting back in to the Shared Digital Health Record for my children or other dependants

Dependant person(s) details

You only need to complete this section if you're requesting to opt out or opt back in to the Shared Digital Health Record health information connector on behalf of your children or other dependants.

To make a request for someone else you must have legal authority to do so.

- For children (under 16 years) you must be a parent or a legal guardian and there must be no court orders in place preventing you from acting for the child concerned.
- For children between the ages of 12 and 15, you will need to get their permission before requesting a copy of their Shared Digital Health Records.
- For adults, Health New Zealand | Te Whatu Ora (Health NZ) prefers to receive the request directly from the person concerned. If a person is unable to make the request themselves, Health NZ will consider requests from legally authorised representatives. These must be accompanied by a clear explanation as to why the person cannot complete the request and evidence of the representative's authority to act on the person's behalf.

Name: _____ DOB: ___ /___ /____ NHI: _____

Relationship to you: ☐ Child under 16 ☐ Adult dependant

Name: _____ DOB: ___ /___ /____ NHI: _____

Relationship to you: ☐ Child under 16 ☐ Adult dependant

Name: _____ DOB: ___ /___ /____ NHI: _____

Relationship to you: ☐ Child under 16 ☐ Adult dependant

Name: _____ DOB: ___ /___ /____ NHI: _____

Relationship to you: ☐ Child under 16 ☐ Adult dependant

Name: _____ DOB: ___ /___ /____ NHI: _____

Relationship to you: ☐ Child under 16 ☐ Adult dependant

Supporting document(s) required

This documentation will be used solely to process your request. It will be securely deleted as soon as that purpose has been met and no copies will be held on file.

If you are emailing your form to us, please attach a copy of your photo ID, proof of relationship and/or lawful authority to act documents. If you are posting your form to us, please include hard copies of the documents.

☐ Photo identity for the person completing this form. For example, copy of driver's licence or passport, which includes signature and expiry date. If you do not hold suitable identification, please submit your request and we will contact you to discuss alternative identification verification options.

For requests for your children (aged under 16)

☐ Proof of relationship confirming you are the child's or children's parent or guardian (for example, birth certificate).

☐ Copies of any current court orders in place in relation to any children for whom the requests are made (if applicable).

For requests for adults you represent

☐ Copies of documents showing the ability to act on behalf of another person (for example, enduring power of attorney, doctor's certificate).

Reason why adult dependant can't make this request:

_____

_____

_____

Declaration

I declare that:

- The information I have supplied is complete and correct.
- I understand the implications of opting out from the Shared Digital Health Record OR
- I understand that by opting back in to the Shared Digital Health Record I am giving permission for my health information to be shared as part of the health information connector service.
- I have authority to act for any dependants listed (where relevant) and have obtained their permission where applicable.

Signature: _____ **Date:** ____ /____ /____

Office use only

Date request received: ____ / ____ / ____ DD MM YYYY	Staff member who received:

Request to opt in/out of Shared Digital Health Record	
All relevant fields completed and declaration signed:	☐ Yes ☐ No (not processed)
Requester ID sighted:	☐ Yes ☐ No (person contacted to discuss) Document type: Expiry date:
Requester ID securely deleted from email and moved to archive folder:	☐ Yes ☐ No

Child/ren opt in/out request - only fill in if this section is relevant	
Proof of relationship provided:	☐ Yes ☐ No (not processed)
Copies of any current court orders:	☐ Yes ☐ No (not processed)
Evidence documentation securely deleted from email and moved to archive folder:	☐ Yes ☐ No
Adult dependant opt in/out request - only fill in if this section is relevant	
Explanation of why person cannot make own request:	☐ Yes ☐ No (not processed)
Copy of authority to act provided:	☐ Yes ☐ No (not processed)
Evidence documentation securely deleted from email and moved to archive folder:	☐ Yes ☐ No

Processing
☐ Form sent to SDHR team for full processing
☐ Form sent to SDHR team for partial processing (some information not supplied)
☐ Form not processed (incomplete information or documentation)
Date of last customer service team action: ____ / ____ / ____ DD MM YYYY