castlemaine HEALTH

FREEDOM OF INFORMATION APPLICATION

APPLICANT'S DETAILS

Relationship to patient: (eg; self,parent,spouse): ……

Surname: …… First Name: ……

Address: ……..

Suburb: …… Postcode: ……

Phone number(s): ……

PATIENT DETAILS

Surname: …… First Name: ……

Date of Birth: …… UR Number (if known): ……

CONSENT

If the applicant is not the subject of this request, the consent of the subject (patient), next of kin or guardian must be obtained.

- ☐ The applicant is completing the request on behalf of the patient, and patient is signing as consent below.

  Patient signature: …… Date: ……
- ☐ The patient is underage or incapacitated and the applicant has the following authority/relationship. *Proof of this relationship is required.*

  ☐ Power of Attorney ☐ Legal Guardian ☐ Senior Next of Kin
- ☐ The patient is deceased. *Requires written permission from the executor or administrator of the deceased person's estate*

INFORMATION REQUESTED

Type of Attendance

☐ Inpatient ☐ Outpatient ☐ Urgent Care

Documents Required

☐ Entire medical record

☐ Part of medical record specify eg; dates of attendance ……

☐ Other specify: ……..

TYPE OF ACCESS REQUIRED

☐ I wish to obtain photocopies of the documents at 20c per copy

☐ I wish to view the original documents at $11.10 per ½ hour viewing time

FEES AND CHARGES

☐ $30.10 application fee (must accompany this form), or

☐ I request to be exempt from payment of the application fee and have included a copy of my current Pension or Health Care Card

In addition to the application fee, charges for searching, photocopying, postage, or viewing may apply. These charges must be paid prior to the documents being released.

Applicants signature: …… **Date:** ……

PLEASE FORWARD YOUR APPLICATION TO:

Freedom of Information Officer
Health Information Services
Castlemaine Health
PO Box 50
Castlemaine Vic 3450
Ph: 5471 13549 | Fax: 5471 3609

Email: medrec@castlemainehealth.org.au