FREEDOM OF INFORMATION (FOI) APPLICATION FORM

The Freedom of Information Officer
Rochester and Elmore District Health Service
PO Box 202 Rochester VIC 3561 Email: rochhosp@redhs.com.au Ph: 03 5484 4400

APPLICANTS DETAILS

First Name:……Surname:…….....

Address:……

Suburb:……..……Postcode:……

Telephone:……Email:……

Relationship to patient: Self/Parent/Other ..... *(Consent on page 2 must be completed if not self)*

PATIENT DETAILS

Firstname:……..Surname:……

Other Names known by:…….....**Date of Birth**:……

Address……

Suburb……Postcode:……

DOCUMENTS REQUESTED

☐ Copy of **part** of the clinical record (please include as much detail as possible regarding the information you require and dates)

……
……
……

☐ Copy of **whole** clinical record

Type of access required: ☐ I wish to obtain a copy of the documents
☐ I wish to view the documents

☐ **IDENTIFICATION** A copy of identification is **mandatory** with this application.
e.g. Current Drivers Licence/Passport and where applicable copy of Health Care Card

APPLICATION FEE $33.60 (NON REFUNDABLE)

The application fee and subsequent access charges are waived if one of the following applies:

- Health Care Card or Pension Card (photocopy both sides)
- Compassionate grounds e.g. patient is deceased

ACCESS CHARGES

Photocopying: 20c per page (black & white, A4)

Applicants Signature…… **Date**……

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CONSENT

Request for Clinical Records relating to Another Person

The patient must sign this authority or you must provide evidence that you have the authority to access this information. If the patient is a child and there are legal circumstances that impact on the release of the child's information**, you must provide evidence that you have the right to access this information**. E.g. Copy of a Family Court Order.

I

……of……

(Patient/NOK) *(Address of patient/NOK)*

do hereby authorise Rochester and Elmore District Health Service to release information about

….....to the above mentioned applicant.

(Patients name/Myself)

Signed…….Date:……

(Patient/NOK Signature)

☐*Specify the evidence supplied*……

Request for Clinical Records relating to a Deceased Patient

Where the patient is deceased, the patient's next of kin must sign the authorisation and provide evidence that they are the next of kin. e.g. Copy of death certificate, proof applicant is the Executor of the Deceased Estate

I

……of……

(Next of Kin) *(Address of NOK)*

do hereby authorise Rochester and Elmore District Health Service to release information about

….....to the above mentioned applicant.

(Patients name/Myself)

Signed…….Date:……

(NOK Signature)

☐*Specify the evidence supplied*……

OFFICE USE ONLY - Rochester and Elmore District Health Service FOI Application

Application Fee: $33.60 received Yes ☐ No ☐

Date Paid……. Receipt Number……..