Freedom of Information Application

Please PRINT clearly, completing ALL details

wdhs Western District Health Service

1. DETAILS OF PATIENT *(person whose information is being requested)*

Surname: ……

Given Name(s): ……

Date of Birth: ……

Address in Medical Record: ……..

..... Post Code: ……..…..……..

2. DETAILS OF APPLICANT *(person requesting the information)*

Surname: ……

Given Name(s): ……

Current Postal address: ……..……

……...……..……..…… Post Code: ……..……..…..…..……..

E-mail: ……..……..……..

Telephone: Home: ……...……. Business: ……..……...…… Mobile: ……..……..…..…….

Relationship to patient: ……..

Signature: ……..……..…… Date: ……..……

3. IDENTIFICATION OF APPLICANT

The applicant must provide official identification showing their current address and signature
*Please tick **ONE** of the following and provide a copy, or present original if applying in person:*

☐ Drivers Licence ☐ Centrelink card ☐ Passport

☐ Other *(please specify)* ……..

Office use only:
☐ Original sighted Initials: ……

4. AUTHORITY FOR RELEASE OF INFORMATION

If the **Applicant is requesting their own information** (ie. is the Patient), no further authorisation is required – *proceed to section 5*

If the **Applicant is requesting information relating to another person**, the below authority must be completed and the relevant supporting evidence (documentation) provided

I, (print name) ……
(Patient/ Patient's legal representative from list below)

do hereby authorise Western District Health Service to release information about the patient to the applicant.

Signature: …….. Date: ……..……

Authority under which this is signed:

- ☐ I am the patient
- ☐ Enacted Medical Enduring Power of Attorney *(provide a copy)*
- ☐ Enacted Medical Treatment Decision Maker *(provide a copy)*
- ☐ Guardianship *(provide a copy)*
- ☐ Administrator *(provide a copy)*
- ☐ Patient is deceased; I am the eldest Next of Kin in a continuing and close relationship
- ☐ Patient is under 18 years of age; I am the legal guardian of the patient (if there are Family Court Orders in place, a copy must be provided)

5. INFORMATION REQUESTED *(if insufficient space, please attach a separate sheet)*

☐ **Part of the patient's records** – please specify the approximate date/s and conditions/s treated:

Date: …… Condition: ……

Date: …… Condition: ……

Please tick the types of documents you require:

- ☐ List of attendances
- ☐ Discharge Summary – a summary of the attendance including presenting condition, treatment, diagnosis and test results
- ☐ Radiology reports
- ☐ Pathology results
- ☐ Emergency department records
- ☐ All documents for the episodes listed above
- ☐ Other (please specify) ……
  ……

☐ **All of the patient's records**

6. REASON FOR REQUEST

Please tick **ONE** to indicate the main reason for your request:

☐ Ongoing medical treatment (your medical practitioner may request this information at no cost – please ask us for more information)

☐ Personal use ☐ Legal

☐ Insurance / TAC claim ☐ Other (please specify) ……..

7. DELIVERY INSTRUCTIONS FOR REQUESTED INFORMATION

Please tick ONE:

☐ I would like the information to be posted to my address provided at section 2 – postage charges will apply

☐ I would like to be notified when the information is ready for collection in person

PLEASE NOTE: In accordance with the Freedom of Information Act, WDHS has **30 days to respond** in writing to your request. This 30 day period begins upon receipt of the written request, appropriate authority and payment of the application fee and deposit (if required)

8. FEES AND CHARGES

Note: Centrelink card holders are exempt from all fees and charges only when the request relates to the personal affairs of the applicant

☐ Centrelink card attached - photocopy both sides

In accordance with the Freedom of Information Act 1982 the following charges apply:

Application Fee:	$31.80 (non-refundable) **payable with application**	
Admin Fee:	$31.30 (flat fee)	
Access charges:	Search/retrieval fee:	$15.00 (flat fee)
	Photocopying:	20 cents per one-sided page
Postage charge:	$15.00 (express post)	

9. SUBMISSION/PAYMENT OPTIONS

Please return your completed application form and supporting documentation, with payment of the application fee by cash, cheque or credit card to:

Post: Freedom of Information Manager
Health Information Department
PO Box 283
Hamilton VIC 3300

In person: Main Reception
Western District Health Service
20 Foster Street, Hamilton

For enquiries please phone: (03) 55518311 **Fax:** (03) 55518240

Office use only:

Application fee payment: ☐ Cash ☐ Cheque ☐ Credit Card

Date paid: Receipt: Initials: ☐ Copy of receipt