FREEDOM OF INFORMATION (FOI) APPLICATION FORM

APPLICANT DETAILS

First Name:……Surname:……

Address:……

Suburb:……Postcode:……

Telephone:……Relationship to patient (ie self/parent/other)……

Email: ……

PATIENT DETAILS

First Name:……Surname:……

Date of Birth:……**Hospital record number: (if known)**……

DOCUMENTS REQUESTED

☐ Copy of **part** of the clinical record (please include as much detail as possible)

Provide description of documents/dates:……

……

OR

☐ Copy of **whole** clinical record

Location of records:

- ☐ Ballarat Hospital
- ☐ Dimboola Hospital
- ☐ Edenhope Hospital
- ☐ Horsham Hospital
- ☐ Stawell Hospital
- ☐ Other: ……

Preferred format of delivery:

- ☐ Documents sent via secure email
- ☐ Documents on USB
- ☐ Printed paper copy

☐ **IDENTIFICATION** Copy of identification that shows your signature is mandatory.
We accept current driver's licence/passport

APPLICATION FEE $34.50 (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 ie. patient is deceased. Authority from next of kin is required (see page 2)

ACCESS CHARGES:

Photocopying: 20c per page (black & white, A4)
Secure email: No charge
For payment options please see page 3

Applicant Signature…… **Date**……

Consent

Request for 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, provide evidence that you have the right to access this information, e.g. a copy of the Family Court Order.

I,……of……
(Patient or Next of Kin) *(Address)*

do hereby authorise Ballarat Health Services to release information

about…… to……
(Patient's Name/Myself) ***(Name of applicant)***

Signed……Date……/……/……
(Patient/Next of Kin signature)

☐ Specify the evidence provided……

Request for 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 the death certificate.

I,……of……
(Next of Kin) *(Address)*

do hereby authorise Ballarat Health Services to release information

about…… to……
(Patient's Name) *(Name of applicant)*

Signed……Date……/……/……
(Next of Kin signature)

☐ Specify the evidence provided……

Send application to/ contact details:

Mail: Freedom of information Officer
Grampians Health
PO Box 577
Ballarat VIC 3353

OR

Email: foi@gh.org.au

Enquiries: 03 5320 4368

Grampians Health ABN: 39089584391 OFFICE USE ONLY Cost Centre /Acct Code: P0905-57815	**Tax Invoice/Receipt** Freedom of Information PO Box 577 Ballarat VIC 3353 AUSTRALIA Telephone: +613 53204368 *Email Address:* *FOI@gh*.org.au

Payment by Credit Card

Requestor Name (if different to name on Credit Card)

Card Type (tick)			
	MasterCard		Visa

Credit Card Number																CVV Number	Expiry date

Name on Card

Signature

Amount
$34.50

Payments maybe made over the phone on 5320 4217 or 5320 4002

Banking details: NAB BSB-083-680 Acc No. 51-583-1460

Important: **Please use the patients name as the reference when depositing money into our account.**

Payment by Cheque or Money Order

Attach the cheque or Money Order to this form and complete the following details.

Cheques are to be made out to **Grampians Health**

Payment From

Date of Cheque/Money Order	

Amount	$34.50

Upon payment this document becomes a Tax Invoice/Receipt

Please keep a copy of this document as no further receipts will be issued