Freedom of Information Application Form

PATIENT DETAILS:

You must provide appropriate identification. We accept your current driver's licence or passport. We may also ask you for additional paperwork in support if relevant.

Last Name:_____ First Name(s):_____

Previous Name (if applicable):_____ Date of Birth: __/__/__

Address: _____

Town/Suburb: _____ Post Code:_____

Telephone: *Work*:_____ *Home/Mobile:*_____

Email: _____

DETAILS OF RECORDS REQUIRED? Please note there may be a fee attached (see over)

❑ I seek a copy of **PART** of the Records ❑ I seek a copy of **ALL** of the Records

❑ I wish to **INSPECT** the records.

Arrangements can be made to view records during standard business hours, charges apply.

If part of the records are required, please tick the documents you require and indicate dates or approximate dates and/or details of the procedure to assist with identification of information.

❑ Urgent Care Department Records
Date/Details: ……

❑ Discharge Summary
Date/Details: ……

❑ Radiology Results (*** see end of form)
Date/Details: ……

❑ Pathology Results
Date/Details: ……

❑ Inpatient Progress Notes
Date/Details: ……

❑ Community Health Notes
Date/Details: ……

❑ Other (please specify)

_____

_____

_____

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_____

_____

If the Applicant **IS NOT THE PATIENT** complete this section and provide the patient's written authorisation to access their records/Medical Power of Attorney OR if a deceased person, consent of the person's next of kin who is of/over the age of 18 years (proof is required).

Applicant Name: _____

Address: _____

Town/Suburb: _____ Post Code:_____

Telephone: *Work*:_____ *Home/Mobile:*_____

Email: _____

Do you have the patient's authority to access this person's medical records? ❑ Yes – please attach written consent. What is your relationship to the patient? _____

FEES AND PAYMENT
The cost varies according to the request.

Application Fee: $33.60 *(non-refundable and must accompany this application unless waived)*
Access Charge: $35.00/hour or part thereof
Photocopying: $0.20 cents per A4 page
Viewing Records: $5.00 per 15 minutes of viewing time or part thereof
Costs are calculated using https://ovic.vic.gov.au/freedom-of-information/access-charges-calculator/

Note: Copies of information is posted by Registered mail or sent by email – liquid-files (secure link) to ensure Privacy. If Registered Mail is required, additional charges apply.

❑ Please send by Registered Post ❑ I agree to pay extra

Payment

Cheque	Please make cheque payable to Benalla Health
Cash	Payable at Hospital Reception between 8.30am–5.00pm Monday to Friday
Credit Card	❑ Visa ❑ Master Card ❑ Other Name on Card:
	Card Number:
	Expiry Date:

Please sign, date and return this Form with copies of required identification and other documents (if applicable) to:

The Freedom of Information Officer
Benalla Health
PO Box 406
BENALLA VIC 3671

Or email to foi@benallahealth.org.au

Or fax to (03) 5761 4246

Applicant Name: _____

Signature: _____ Date: _____

APPLICATION – TIME FRAME
The applicant will be notified of a decision as soon as practicable within 30 days of receiving a fully completed valid request.

******* PLEASE NOTE *Benalla Health is able to provide copies of plain x-rays in relation your request, but if the patient has had out-patient CT Scans and Ultrasounds, we are unable to provide copies of reports. These services are provided by* ***Goulburn Valley Imaging*** *which is a private provider located on Benalla Health's premises. To obtain these reports, please contact*
*Goulburn Valley Imaging, PO Box 261, Benalla Victoria 3671. ****

Office Use Only:
Date received: _____ ❑ ID Confirmed ❑ On Database ❑ Complete _____
Records accessed: ❑ Benalla Health (Hospital) ❑ Benalla Health (Community Health)
❑ Other (*specify*):_____