Benalla HEALTH

Freedom of Information Application Form

PATIENT/CLIENT DETAILS:

A COPY OF IDENTIFICATION IS MANDATORY. WE ACCEPT A COPY OF YOUR CURRENT DRIVER'S LICENCE OR PASSPORT

Surname:______________________________ Given Name(s):______________________________

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

Address: ____

Town/Suburb: ____ Post Code:________________

Telephone: *Work*:_________________________ *Home/Mobile:*________________________________

Email Address: ____

RECORDS REQUIRED?

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

If part of the record is required, please tick the part(s) of the documents you require and indicate the dates or approximate dates

❑ Urgent Care Department Records ____

❑ Discharge Summary ____

❑ Radiology Results*** *(refer to note at the end of form)* ____

❑ Pathology Results ____

❑ Inpatient Progress Notes ____

❑ Community Health Notes ____

❑ Other (please specify) ____

or

❑ I wish to inspect the records
(arrangements can be made to view your records during standard business hours and charges are applicable).

If the Applicant **IS NOT THE PATIENT** we will require the following section to be completed and:

- The patient's written authorisation to access the patient's records OR
- In the case of a deceased person, the consent of the person's senior available next of kin who is of or above the age of 18 years ***(proof of this relationship is required)***

Applicant Name: ____

Applicant Address: ____

Town/Suburb: ____ Post Code:________________

Telephone: *Work*:_________________________ *Home/Mobile:*________________________________

Email Address: ____

Do you have the patient's authority to access his/her medical records?

❑ Yes – please attach written consent.

What is your relationship to the patient? ____

FEES AND PAYMENT OPTIONS

The total cost varies according to the type of request. An application for Financial Hardship may be made and must be supported by evidence, such as a HealthCare Card or Pension Card. If accepted, you may be excused from paying some or all of the following charges

Application Fee: $28.40 *(non-refundable and must accompany the application where applicable)*
Search Fee: $20.00
Photocopying: $0.20 cents per A4 page
Viewing Records: $5.00 per 15 minutes of viewing time or part thereof

Note: All requests are posted via regular post. If Express Post or Registered Mail is required, please nominate this when submitting your application. Additional charges will apply.

Payment methods

Cheque	Please make payable to Benalla Health
Cash	Payable at the Hospital's Reception Desk 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 the completed Application Form with the required identification and any other documents (if applicable) to:

The Freedom of Information Officer

Benalla Health or email: foi@benallahealth.org.au
PO Box 406
Benalla Victoria 3671 or fax: (03) 5761 4246

Name: ______________________________

Signature: ______________________________ Date: ____________________

APPLICATION PROCESS – TIME FRAME

The applicant will be notified of a decision as soon as practicable within 45 days of receiving the fully completed request.

*** *Benalla Health is able to provide copies of plain x-rays in relation your request, but if you or the patient/client has had out-patient CT Scans and Ultrasounds, we are unable to provide copies of reports. These services are provided by Broken River Imaging who is a private provider located on Benalla Health's premises. To obtain these reports, please contact them direct at Broken River 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 (*please specify*):______________________________