FREEDOM OF INFORMATION (FOI) APPLICATION FORM

Central Highlands Rural Health

The Freedom of Information Officer
Administration
Central Highlands Rural Health
PO Box 465 DAYLESFORD VIC 3460 Email: info@chrh.org.au Ph. 03 5321 6500

APPLICANTS DETAILS

First Name:……………………………………………………Surname:……………………………….................

Address:………

Suburb:………………………………………………...…………Postcode:……………………………………………

Telephone:………………………………………………Email:…………………………………………………………

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

PATIENT DETAILS

First Name:………………………………………………..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, include CHRH campuses document types 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.
Eg. Current Drivers Licence/Passport and where applicable copy of Health Care Card

APPLICATION FEE $30.60 (NON REFUNDABLE)	**ACCESS CHARGES**
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 eg. patient is deceased	Photocopying: 20c per page (black & white, A4) CD: \$20 (patient attendances post 24th July 2018)

Applicants Signature…………………………………………………**Date**………………………………………

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**. Eg. Copy of a Family Court Order.

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

do hereby authorise Central Highlands Rural Health 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. Eg. Copy of death certificate, proof applicant is the Executor of the Deceased Estate

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

do hereby authorise Central Highlands Rural Health to release information about

……………………………………………………………………………………… to the above mentioned applicant.
(Patients name/Myself)

Signed……………………………………………………………………………….Date:………………………………………
(NOK Signature)

☐ *Specify the evidence supplied*……………………………………………………………………………………………

Central Highlands Rural Health – FOI Application – Office USE ONLY

Application Fee: $30.60 received Yes No Date Paid……………………………………………………….

Receipt Number………………………………………..**Date** ………………………………………………………………..

Staff Name (Please Print)……………………………………………………………………………………………………