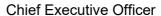
FREEDOM OF INFORMATION (FOI) APPLICATION FORM

HEYWOOD

The Freedom of Information Officer





Email: info@heywoodruralhealth.vic.gov.au Ph. 03 5527 0528

APPLICANTS DETAILS		
First Name:	.Surname:	
Address:		
Suburb:	Postcode:	
Telephone:Email:		
Relationship to patient: Self/Parent/Other	(Consent on p.g. 2 must be completed if not self)	
Totalionship to patient. Odin architother(Odisenton pg 2 mast be completed in not sell)		
PATIENT DETAILS		
First Name: Surname:		
First NameSurname		
Other Newscales are live and him		
Other Names known by:		
Address		
Address		
Suburb	Postcode:	
DOCUMENTS REQUESTED		
☐ Copy of part of the clinical record (please include as m	uch detail as possible regarding the information including	
document types and dates)		
☐ Copy of whole clinical record		
Sopy of Whole difficulty		
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 (Current Drivers Licence/Passport)		
APPLICATION FEE \$33.60 (NON REFUNDABLE)	ACCESS CHARGES	
The application fee and subsequent access charges are		
waived if one of the following applies:	Photocopying: 20c per page (black & white, A4)	
Health Care Card or Pension Card	Search charge: \$20.00 per hour or part of an hour	
Compassionate grounds e.g. patient is deceased		
Evidence of hardship is provided		

CONSENT		
Request for Clinical Records relating to Another Pers		
The patient must sign this authority, or you must provide evidence that you have the authority to access this information (Power of Attorney evidence). 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 . E.g. Copy of a Family Court Order.		
Iof		
(Patient/NOK)	(Address of patient/NOK)	
do hereby authorise Heywood 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		
the next of kin. e.g. Copy of death certificate, proof applicant is the Executor of the Deceased Estate		
of		
(Next of Kin)	(Address of NOK)	
do hereby authorise Heywood Rural Health to release information about		
	to the above-mentioned applicant.	
(Patients name/Myself)		
Cignod	Date:	
Signed(NOK Signature)	Date:	
(NON Signature)		
□ Specify the evidence supplied		
Specify the evidence supplied		
Heywood Rural Health – FOI Application – Office USE ONLY		
neywood Rafairicaidi Tor Application Office GOL ONLT		
Application Fee: \$33.60 received Yes No Date	Paid	
Date		
Receipt NumberDate	a	
Toodpt Humbor	·	
Staff Name (Please Print)		

More information and fees are set by government regulations. A copy can be downloaded from: http://www.legislation.vic.gov.au

PH: (03) 5527 0555 Fax: **(**03**)** 5527 1900 ABN: 13 439 112 909