

## FREEDOM OF INFORMATION (FOI) APPLICATION FORM

### The Freedom of Information Officer

Chief Executive Officer

Heywood Rural Health, PO Box 159, HEYWOOD VIC 3304

Email: [info@heywoodruralhealth.vic.gov.au](mailto: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 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 including document types and dates)

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.....  
.....

- ☐ 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 (Current Drivers Licence/Passport)

#### APPLICATION FEE \$33.60 (NON REFUNDABLE)

The application fee and subsequent access charges are waived if one of the following applies:

- Health Care Card or Pension Card
- Compassionate grounds e.g. patient is deceased
- Evidence of hardship is provided

#### ACCESS CHARGES

Photocopying: 20c per page (black & white, A4)

Search charge: \$20.00 per hour or part of an hour

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 (**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.

I ..... of .....  
(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 sign the authorisation and provide evidence that they are the next of kin. e.g. Copy of death certificate, proof applicant is the Executor of the Deceased Estate

I ..... 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)

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

☐ Specify the evidence supplied.....

### **Heywood Rural Health – FOI Application – Office USE ONLY**

Application Fee: \$33.60 received Yes No Date Paid.....

Receipt Number.....Date.....

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>