Freedom of Information Application
Patient Records

Please PRINT clearly, completing ALL details

1. APPLICANT DETAILS

Surname: .....

Given Name(s): ..... Date of Birth: .....

Residential address: .....

..... Post Code: .....

Postal address: .....

..... Post Code: .....

Email: .....

Telephone: Home: ..... Business: ..... Mobile: .....

Signature: ..... Date: .....

2. PATIENT DETAILS *(person whose information is being requested)* – ***write 'AS ABOVE' if same as applicant***

Surname: .....

Given Name(s): .....

Date of Birth: .....

Applicant's relationship to patient: .....

3. IDENTIFICATION OF APPLICANT

The *applicant* must provide official identification showing their signature

*Please tick **ONE** of the following and provide a copy, or present original if applying in person:*

☐ Driver's License ☐ Centrelink card ☐ Passport

☐ Other *(please specify)* .....

Office use only:

☐ Original sighted Initials: .....

Note: If Centrelink card is presented, a photocopy must be attached to this application

4. AUTHORITY FOR RELEASE OF INFORMATION

If the **Applicant is requesting their own information** (ie. is the Patient), no further authorisation is required – *proceed to section 5*

If the **Applicant is requesting information relating to another person**, the below authority must be completed and the relevant supporting evidence (documentation) provided

I, (print name) .....
(Patient / Patient's legal representative from list below)

do hereby authorise Northeast Health Wangaratta to release information about the patient to the applicant.

Signature: ..... Date: .....

Authority under which this is signed:

I am the patient

Enacted Medical Enduring Power of Attorney *(provide a copy)*

Appointed Medical Treatment Decision Maker *(provide a copy)*

Guardianship *(provide a copy)*

Administrator *(provide a copy)*

Patient is deceased; I am the Senior Available Next of Kin *(provide proof)*

Patient is under 18 years of age; I am the legal guardian of the patient *(if there are Family Court Orders in place, a copy must be provided)*

Northeast Health Wangaratta PO Box 386 Wangaratta VIC 3676 Green Street Wangaratta VIC 3677
Telephone: (03) 5722 5111 **Facsimile:** (03) 5722 5109 **Website:** www.northeasthealth.org.au **ABN** 13 157 273 279

5. INFORMATION REQUESTED *(if insufficient space, please attach a separate sheet)*

☐ **Part of the patient's records** – please specify the approximate date/s of admission and condition/s treated:

Dates: ..... to ..... Condition: .....
Dates: ..... to ..... Condition: .....

Please tick the type(s) of documents you require:

☐ List of attendances
☐ Discharge Summary – a summary of the attendance including presenting condition, treatment, diagnosis and test results
☐ Radiology (eg. xray/scan) reports
☐ Pathology results
☐ Emergency Department records
☐ All documents for the episodes listed above
☐ Other (please specify) .....

☐ **Entire medical record** (includes all presentations to NHW)

6. REASON FOR REQUEST

*Please tick **ONE** to indicate the main reason for your request:*

☐ Ongoing medical treatment (your medical practitioner may request this information at no cost – please ask us for more information)
☐ Personal use
☐ Legal
☐ Insurance / TAC claim
☐ Other (please specify) .....

7. DELIVERY INSTRUCTIONS FOR REQUESTED INFORMATION

Please tick ONE:
☐ I would like the information posted to my address provided at section 1 – postage charges will apply
☐ I would like to be notified when the information is ready for collection in person

PLEASE NOTE: In accordance with the Freedom of Information Act, NHW has **30 days to respond** in writing to your request. This 30 day period begins upon receipt of the written request, appropriate authority and payment of the application fee and, if applicable, payment of deposit.

8. FEES AND CHARGES

Note: Centrelink card holders are exempt from all fees and charges **only when the request relates to the personal affairs of the applicant**

☐ Centrelink card attached – photocopy both sides

In accordance with the Freedom of Information Act 1982 the following charges apply:

Application Fee:	$30.00 (non-refundable) **payable with application**	
Access Charges:	Search time:	$22.20 per hour or part thereof in 15 minute increments
	Photocopying:	20 cents per one-sided page
	Information on CD:	$20.00
Postage Charge:	$3.50 (for Australia Post tracking) plus the actual cost of postage	

Note: If the Access Charges are estimated to be in excess of $50.00, you will be requested to pay a deposit

9. SUBMISSION / PAYMENT OPTIONS

Please return your completed application form and supporting documentation, with payment of the application fee by cash, cheque or credit card to:

Post: Freedom of Information Officer
Northeast Health Wangaratta
PO Box 386
Wangaratta Vic 3676

For enquiries please phone 03 5722 5111

In person: **Main Reception**
Northeast Health Wangaratta
35-47 Green Street, Wangaratta

Email: FOI@nhw.org.au

Fax: 03 5722 5109

Office Use Only:

Application Fee payment: ☐ Cash ☐ EFT ☐ Cheque ☐ Credit Card
Date paid: Receipt Number: Initials: ☐ Copy of receipt attached

Tax Invoice / Receipt

Medical Administration
Northeast Health Wangaratta
35-47 Green Street
PO Box 386
Wangaratta Vic 3676

Telephone: (03) 5722 5111
Facsimile: (03) 5722 5109
Email: foi@nhw.org.au

ABN: 13 157 273 279

Office Use Only:
Cost Centre / Acct Code: P0902 – 57506

Please complete the following details and tick method of payment

Payee Name

Payment of FOI Application Fee for health information for the following patient:

Patient Name	Date of Birth

☐ Payment by EFT

So that we can correctly identify your payment, please email this form to accountsreceivable@nhw.org.au or fax to 03 5722 5109, once payment is made

Northeast Health Wangaratta
Westpac – Wangaratta
BSB: 033-260 Account: 94-1465

Date of EFT payment		Amount	$30.00

☐ Payment by Credit Card

Complete credit card details and submit this form with your written request for information

Card Type (tick)			
	VISA		Mastercard

Credit Card Number	CVV Number	Expiry Date

Name on Card

Cardholder signature		Amount	$30.00

☐ Payment by Cheque or Money Order

Attach a cheque or money order made out to **Northeast Health Wangaratta** to your official request for information.

Amount	$30.00

Upon payment this document becomes a Tax Invoice/Receipt

Please keep a copy as no further receipts will be issued