FREEDOM OF INFORMATION (FOI) APPLICATION FORM

The Freedom of Information Officer
Health Information Services
PO Box 577 BALLARAT VIC 3353

Ph: 03 5320 4368 **Fax**: 03 5320 4829
Email: foi@bhs.org.au

APPLICANT DETAILS

First Name:……Surname:……

Address:……

Suburb:……Postcode:……

Telephone:……Relationship to patient (ie self/parent/other)……

Email: ……

PATIENT DETAILS

First Name:……Surname:……

Date of Birth:……**Hospital record number: (if known)**……

DOCUMENTS REQUESTED – PLEASE CHOOSE 1 OPTION ONLY

☐ Copy of **part** of the clinical record (please include as much detail as possible)

Provide description of documents/dates:……

OR ……

☐ Copy of **whole** clinical record

Type of Access Required
☐ I wish to obtain a copy of the documents
☐ I wish to view the documents

☐ I would like the CD containing medical records password protected

PASSWORD:……

☐ **IDENTIFICATION** Copy of identification that shows your signature is **mandatory**.
We accept current driver's licence/passport

☐ **APPLICATION FEE $30.10** (non-refundable)

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 ie. patient is deceased. Authority from next of kin is required (see page 2)

ACCESS CHARGES:

Photocopying: 20c per page (black & white, A4)
CD: $20.00

For payment options please see page 3

Applicant Signature…… **Date**……

Consent

Request for 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, provide evidence that you have the right to access this information, e.g. a copy of the Family Court Order.

I,……of……

(Patient or Next of Kin) *(Address)*

do hereby authorise Ballarat Health Services to release information

about…… to……

(Patient's Name/Myself) *(Name of applicant)*

Signed……Date……/……/……

(Patient/Next of Kin signature)

☐ Specify the evidence provided……

Request for 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 the death certificate.

I,……of……

(Next of Kin) *(Address)*

do hereby authorise Ballarat Health Services to release information

about…… to……

(Patient's Name) *(Name of applicant)*

Signed……Date……/……/……

(Next of Kin signature)

☐ Specify the evidence provided……

Send application to:

Mail: Freedom of information Officer
Ballarat Health Services
PO Box 577
Ballarat VIC 3353

OR

Email: foi@bhs.org.au

Enquiries: 03 5320 4368

Ballarat Health Services ABN: 39089584391 OFFICE USE ONLY Cost Centre /Acct Code: P0202-57815	**Tax Invoice/Receipt** Health Information Services 1 Drummond Street North PO Box 577 Ballarat VIC 3353 AUSTRALIA Telephone: +613 53204368 Facsimile: +613 5320 4829 *Email Address:* foi@bhs.org.au

Payment by Credit Card

Requestor Name (if different to name on Credit Card)

Card Type (tick)			
	MasterCard		Visa

Credit Card Number															CVV Number	Expiry date

Name on Card

Signature

Amount
$30.10

Payments maybe made over the phone on 5320 4217 or 5320 4002

Banking details: ANZ-Ballarat BSB-013-516 Acc No. 837220814

Important: Please use the patients name as the reference when depositing money into our account.

Payment by Cheque or Money Order

Attach the cheque or Money Order to this form and complete the following details.

Cheques are to be made out to **Ballarat Health Services**

Payment From

Date of Cheque/Money Order	

Amount	$30.10

Upon payment this document becomes a Tax Invoice/Receipt

Please keep a copy of this document as no further receipts will be issued