

# Request for Access to Client Record

To be filled in by the applicant and forwarded to:-  
The Freedom of Information Officer  
Great Ocean Road Health  
Albert Street  
Lorne VIC 3232  
Any Cheques / Money Orders are to be made payable to Great Ocean Road Health.



## Applicant Details

First Name: ..... Surname: .....  
Address: .....  
..... Postcode: .....  
Contact Number: ..... Relationship to Patient: (eg. Self/Parent/Other) .....

## Client Details

First Name: ..... Surname: .....  
Address (in record): .....  
..... Postcode: .....  
Date of Birth: ..... Record Number (if known): .....

## Information Requested: Application fee \$29.60 plus search time @ \$22.22 per hour (or part thereof) and photocopy charge 20c per page

Please tick

- Appointment to view medical record
- Photocopy of **part** of the medical record (please fill out details below as specific as possible)
  - Dates of admission required (if known) .....
  - Treatment for: .....
- Photocopy of **whole** medical record
- By having Great Ocean Road Health provide my authorised person with a copy of the information.

**Authorised Person** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

I understand that charges will be made in respect of this request in accordance with the Freedom of Information Act. A statement of charges will be supplied and must be paid prior to release of information.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## OFFICE USE ONLY

Identification Sighted by: ..... Type of Identification .....