

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 are to be made payable to Great Ocean Road Health.
Electronic Funds Transfer – BSB: 063-708 Account: 1003 1800



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 \$30.58 plus search time @ \$22.50 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

Authorisation of Request for Access Client Record

To be filled with FOI Application Form and relating paperwork

CLIENT DETAILS

Name:

UR Number:

Full Access Granted

No Access Granted

Partial Access Granted

The following areas cannot be accessed:-

1.

3.

2.

4.

Section of the Act denying access: -

.....
.....

DECISION MAKER

Name:

Position:

Signature:

Date:

Comments:

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.....
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