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: Photo Identification Required. Application fee $31.80 plus search time @ $23.85 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: -

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DECISION MAKER

Name: …… Position: ……

Signature: …… Date: ……

Comments:

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