# **FREEDOM OF INFORMATION (FOI) APPLICATION FORM**

**The Freedom of Information Officer**



Health Information Services **Ph**: 03 5320 4368 **Fax**: 03 5320 4829

PO Box 577 BALLARAT VIC 3353 Email: foi@bhs.org.au

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| **APPLICANT DETAILS**First Name:……………………………………………..……………Surname:………………………………………………………………………………..……Address:………………………………………………………………………………………………………………………………………………………………………Suburb:…………………………………………………………………………………………Postcode:……………………………………………………………..Telephone:…………………………………………………Relationship to patient (ie self/parent/other)…………………………………………Email: ……………………………………………………………………………………………. |

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| **PATIENT DETAILS**First Name:…………………………………………………………...Surname:……………………………….…………………………………………………….**Date of Birth:**…………………………..………..………………….**Hospital record number: (if known)**…………………….……………………. |

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| **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:……………………………………………………………………………………………………………………………………………………...** |

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

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| □ **APPLICATION FEE $29.60** (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: $20.00For payment options please see page 3 |

**Applicant Signature**……………………………………………………………………………. **Date**………………………………………………………



# **Consent**

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| **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)*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 me. *(Patient’s Name/Myself)*Signed…………………………………………………………………………………………………………Date……………………/………………/…….………… *(Next of Kin signature)*□ Specify the evidence provided…………………………………………………………………..…………………………………………………… |
| **Send application to:****Mail**: Freedom of information Officer OR **Email**: foi@bhs.org.au Ballarat Health Services PO Box 577 Ballarat VIC 3353**Enquiries**: 03 5320 4368 |
| ABN: 39089584391OFFICE USE ONLYCost Centre /Acct Code: P0202-57815 | **Tax Invoice/Receipt**Health Information Services1 Drummond Street NorthPO Box 577 Ballarat VIC 3353 AUSTRALIATelephone: +613 53204368Facsimile: +613 5320 4829*Email Address:* foi@bhs.org.au |

**Payment by Credit Card**

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| --- | --- | --- |
| Requestor Name (if different to name on Credit Card) |  | Card Type (tick) |
|  |  |  | MasterCard |  | Visa |

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| Credit Card Number  | CVV Number | Expiry date |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Name on Card |
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| Signature |  | Amount |
|  |  | $29.60 |

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.

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**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**

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| Payment From |
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| --- | --- | --- | --- | --- |
| Date of Cheque/Money Order |  |  | Amount | $29.60 |

**Upon payment this document becomes a Tax Invoice/Receipt**

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