FREEDOM OF INFORMATION APPLICATION FORM

PATIENT

Surname: ______________________________ Given Name: _________________________

Date of Birth: ________________ UR Number (if known): _______________________

APPLICANT

Surname: ______________________________ Given Name: _________________________

Address: ____

Phone number (home): ______________________ (work) ____________________________

Relationship to Patient: ____

INFORMATION REQUIRED FROM THE MEDICAL RECORD

Type of Attendance (please tick box)
Inpatient ☐ Outpatient ☐ Accident & Emergency ☐

Documents Required (please tick box)
Entire medical record ☐
Part of medical record ☐ (specify) ____

TYPE OF ACCESS REQUIRED (please tick box)
I wish to obtain photocopies of the above documents at 20c per copy* ☐
I wish to view the original documents in my medical record at $10 per ½ hour viewing time* ☐

SIGNED: ____

DATE: _______/______/_________

APPLICANTS WISHING TO OBTAIN ACCESS TO A MEDICAL RECORD OTHER THAN THEIR OWN, MUST PROVIDE A SIGNED AUTHORITY FROM THE PATIENT CONCERNED. WHERE THE PATIENT IS DECEASED, THE PATIENT'S NEXT OF KIN MUST SIGN THE AUTHORISATION.

AUTHORISATION FOR RELEASE OF INFORMATION FROM A MEDICAL RECORD

I, ________________________________ of ____
(name) (address)
do hereby authorise the Mt Alexander Hospital to release information from
____ medical record to
(patient's full name)
________________________________ of ____
(applicant's name) (applicant's address)

SIGNED: ____

DATE: ______/______/_________

PLEASE FORWARD THIS APPLICATION WITH APPLICATION FEE OF $23.40 TO:

Health Information Services
Mt Alexander Hospital
P.O. Box 50
Castlemaine 3450