Title:	Freedom of Information Request Form			
Section:	Information Management	PRH:	Chief Executive Officer	F.IM.002

ALEXANDRA DISTRICT HEALTH

PATIENT DETAILS

Surname		Date of Birth	
Given Name(s)			
Address			
Phone Numbers		Fax Number	
Email			

APPLICANT DETAILS

Are you applying for information about another person? If YES please complete details below.

Surname		Given Name(s)	
Address			
Phone Number		Fax Number	
Email			
Relationship to Patient		Signature	

If you are applying for information about another person they must provide you with their written consent or provide evidence that you have been named as Enduring Power of Attorney and/or Medical Treatment Decision Maker, Legal Guardian or are the direct Next of Kin in the case of a deceased person.

DETAILS OF REQUEST:

Describe clearly the documents you wish to access, including dates, subject matter or any other information that would help identify the documents you are requesting.

Common documents contained in the Medical Record include: Discharge Summaries; Urgent Care Notes; Progress Notes; Medication Records; Operation Reports; Anaesthetic Records and Pathology Results.

FORM OF ACCESS (PLEASE CIRCLE):

Yes / No - Please provide me with the documents via encrypted email to my nominated email address.

Yes / No - Please provide me with a photocopy of the documents and I will collect them.

Yes / No - Please provide me with a photocopy of the documents and mail them by Registered Post.

Yes / No - Please arrange for someone to sit with me whilst I look at the documents.

FEES AND CHARGES

I understand that charges apply under the Freedom of Information Act 1982 (Vic). In some circumstances the application fee may be waived (e.g. if you provide your health care card), however some fees may still apply, (i.e. photocopying and mailing),

Application fee: $29.60 non-refundable. Please tick how you are paying.

☐ Cheque – please make cheque payable to Alexandra District Health
☐ Paid in person – please attend Reception between 8.30am and 4.30pm
☐ Request application fee to be waived – please provide a photocopy of your Health Care Card.
☐ Credit Card – please complete details below

Card Number:	CCV:	
Cardholder Name:	Expiry Date _____ / _____	
Signature:	Amount $	

You may be invoiced for photocopying (20c per page) and/or postage ($11.00 Registered Mail) and this would need to be paid prior to completion of the request, if applicable.

CHECKLIST: Please tick that you have completed and attached as applicable

☐ Patient details
☐ If you are applying for information about another person complete the applicant details.
☐ Details of request
☐ Form of Access
☐ Application Fee
☐ Copy of Photo Identification (must include full name, photo and signature)
☐ Copy of Healthcare Card (if applicable)
☐ Patient Consent or Evidence of authority (if applicable)

Please forward completed form to:

Mail: Alexandra District Health
PO Box 21
Alexandra Vic 3714

In person: Alexandra District Health
12 Cooper Street
Alexandra Vic 3714

Email: ADHFreedomofInfo@adh.org.au

Fax: 5772 1094

OFFICE USE ONLY	
FOI Register Number:	Date Received:
Application Fee Paid: YES / NO	Details:
Letter sent to applicant advising application received:	Date Sent:
Patient UR number:	
Request Approved/Denied and by whom:	
Details of approval or denial:	
Details of other fees:	
Additional Comments	