FREEDOM OF INFORMATION (FOI) REQUEST & AUTHORISATION FORM

Barwon Health

Mail, fax or email Request and Authorisation Form to:

The Freedom of Information Officer
Information Services, Barwon Health,
P.O. Box 281 | GEELONG | VIC | 3220
Phone: 03 4215 1168 | **Fax:** 03 4215 124 | **Email:** FOI@barwonhealth.org.au

APPLICANT'S DETAILS

Relationship to patient: (i.e. self/parent/other): .....

Surname: ..... First Name: .....

Address: .....

Suburb: .....Postcode: .....

Telephone: ..... Email: ……..

PATIENT DETAILS

Surname: ..... First name: .....

Date of Birth: ..... **Health record number: (if known):** .....

INFORMATION REQUESTED

☐ Copy of **part** of the health record (Please select service/s and include as much detail as possible)……...

……..

☐ Acute Hospital Services ☐ Mental Health, Drug and Alcohol Services ☐ Community Health ☐ Aged Care

- Dates of admission required (if known): .....
- Treatment for: ….....

☐ Copy of **whole** health record ☐ Appointment to view health record

FEES AND CHARGES:

Application fee (Fee waved for Health Care Card or Pension Card holders)	**$28.90**
Other fees and charges that may be applicable	
Photocopying/printing:	**20c** per page
Images to disc:	**$25**
Postage Charges (Registered Mail):	**$10**

Cheques/Money Orders are to be made to Barwon Health
A Statement of Charges will be supplied and MUST BE PAID prior to release of information – where copy costs are estimated to be over $50 a deposit will be requested

IDENTIFICATION & AUTHORISATION: The following must be provided with your request before it can be processed

- ☐ Identification – photo ID e.g. copy of drivers licence, passport (required by all applicants)
- ☐ Application fee **OR** copy of Health Care Card or Pension Card if fees waived
- ☐ If applicant is not the patient, written consent of the patient or any relevant legal papers indicating authority to access

Signature: .....Date: ...../……/……..

ADMINISTRATION: BARWON HEALTH USE ONLY

Date Received: ……/……../…….. Date Valid ……./……./……. Date Due: ……./……../……

☐ DMR ☐ Other: …….. ……. ☐ CHECKED

BHS01400X

THE SECTIONS BELOW ARE FOR 'BARWON HEALTH' USE ONLY

PATIENT DETAILS

Name: ..... UR: .....

FOI REVIEWER

☐ No exemptions identified ☐ Exemptions identified

FOI Reviewer Name (Print) …….. Date ……/……/……..

Any other comments:.....

MEDICAL HEALTH RECORD APPROVAL

☐ Full access granted ☐ Partial access granted

☐ No access granted ☐ Approved for viewing with GP only

Which areas cannot be accessed.....

……

Section/s of Act denying access ……....

……

Decision maker's signature ……Date ……/……/…….....

Name (Please print).....

Any other comments:.....

MENTAL HEALTH RECORD APPROVAL

☐ Full access granted ☐ Partial access granted

☐ No access granted ☐ Approved for viewing with GP only

Which areas cannot be accessed? .....

……

Section/s of the Act denying access ……..

……

Decision maker's signature.....Date……/……/……

Name (Please print).....

Any other comments:.....