Austin HEALTH

FOI Application

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ……..……

AFFIX PATIENT LABEL HERE

FAH018100

Patient Details

Surname……Given Names……..……..

Address……..……

Phone Number *(home)* …… *(other)* ……

Email Address.....

Date of Birth…… UR Number *(if known)* ……

Applicant (if different from above)

Surname……Given Names……..……

Address……..……

Phone Number *(home)* …… *(other)* ……..

Email Address.....

Relationship to patient……....

For Access to a Child's Record:

Is the child subject to a Family Court Order? ☐ **NO** ☐ **YES** (attach a copy of the Court Order)

1) Service Contact

☐ Austin Hospital / Heidelberg Repatriation Hospital / Royal Talbot Rehabilitation Centre

☐ Fairfield Hospital (Year)…… ☐ Psychiatric Services ☐ NCASA

2) Information Required from the Medical Record *(Please tick ONE option only)*

☐ Entire Medical Record **OR** ☐ Part of Medical Record

If requesting a "part of medical record" ONLY please provide description of documents / dates……

……

……

3) Do You Require Pathology and Radiology Results?

☐ No ☐ Yes (please specify date range) ……..……

4) Type of Access Required (*Please tick ONE option only)*

☐ I wish to obtain the documents electronically via Microsoft OneDrive*

($15.00 fee – waived for Health Care Card/Pension Card holders)

*Confirm Email address for One Drive: ……

☐ I wish to obtain a DVD copy of the documents via Registered Post **(additional fees may apply – refer to *'Other Access Charges that may apply'* within the Information for Consumers form)**

☐ I wish to view the documents **(additional fees may apply - refer to *'Other Access Charges that may apply'* within the Information for Consumers form)**

See next page

FOI Application

L15.0

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Authority for Release of Information

Request for Records Relating To You

Signed ……..…… Date …..……/……..…/…….
(Patient Signature)

☐ Photo identification provided .....

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 on behalf of the patient.* Any additional information can be provided in the space below.
- 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. Any additional information can be provided in the space below.
- In relation to a deceased patient, access by the most senior available next of kin is not guaranteed. To assist us in assessing your application and making an informed decision regarding the release of a deceased patient's record, please explain the purpose of your application and why you believe it is reasonable to release the records to you.

I, ……..of……..
(Insert Name) *(Address)*

hereby authorise Austin Health to release information about ……
(Patient's Name)

to the aforementioned applicant.

Signed…….....…… Date……/……..…/…….
*(Next of Kin signature) **

Additional Information:

……

……

……

* Please attach a copy of relevant documentation to support your authority. (For example: Death Certificate if relevant, POA, MTDM, Guardianship Order)

Send application to:

Mail: Freedom of Information Office
Austin Health
PO Box 5555
Heidelberg, VIC 3084

OR

Email: foi@austin.org.au

Enquiries: +613 9496 3103

Austin HEALTH

Australian Business Number (ABN): 96 237 388 063

Do not scan into SMR

Office Use Only:
Cost Centre / Acct Code: P0205 – 57506
Revenue is GST Out of Scope
MX 113

Tax Invoice/Receipt

Health Information Services
145 Studley Road
PO Box 5555
Heidelberg, VIC 3084, AUSTRALIA
Telephone: +613 9496 3103
Facsimile: +613 9458 4557
Email Address: foi@austin.org.au

IMPORTANT: If paying by Direct Deposit or a Direct Credit Card payment, to ensure that your payment is clearly associated with your application, please use a unique reference number "FOI and the patient's Surname" For example: "FOI – Robinson".
This will ensure a quicker process and no delay in activating or processing your request.

Please note Upon payment of the charges prescribed this document becomes your tax invoice/receipt. No further receipts will be issued

1) Payment by Credit Card

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

Credit Card Number																	CVV Number				Expiry date	

Name on Card			
Signature		Amount	$

2) Payment via Direct Deposit

Account Name:	Austin Health
Bank:	WESTPAC BANKING CORPORATION
BSB Number:	033-286
Account Number:	120120
Unique Ref number:	FOI – *Patient's Surname – *eg: FOI-Robinson

3) 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 **Austin Health.**

Payment From			
Date of Cheque / Money Order		Amount*	$