

Alfred Sandringham Caulfield

Unit:.....

FREEDOM OF INFORMATION APPLICATION

UR:

Surname

Given Names

APPLICATION FOR DOCUMENTS CONTAINING PATIENT INFORMATION

Medical Services
PO Box 315, PRAHRAN VIC 3181
T: 9076 3002 F: 9076 2825



	The Alfred		Sandringham Hospital
	Alfred Psychiatry		Caulfield Hospital
	Waiora Clinic		Caulfield Hospital Aged Psychiatry Services
	Junction Clinic		Melbourne Sexual Health Centre
	Child & Adolescent Mental Health Service		Other

For office use only	
UR No	<input type="text"/>
FOI No	<input type="text"/>
ID Type	<input type="text"/>
ID No	<input type="text"/>

PATIENT DETAILS

Mr/Mrs/Ms/Other: _____

Address: _____

Suburb _____ Post Code: _____

Date of Birth: _____

Private Ph No: _____ Mobile No: _____

Business Ph No: _____ Fax No: _____

E-mail address: _____

IF APPLICANT IS NOT THE PATIENT

***Please Note:** If the applicant is not the subject of the request for personal information, then the consent of the subject must be obtained. In the case of a deceased person, the consent of the person's most senior person responsible who is of or above the age of 18 years is required. **Proof of this relationship is required.**

Name: _____ Relationship: _____

Address: _____

Suburb _____ Post Code: _____

Private Ph No: _____ Mobile No: _____

Business Ph No: _____ Fax No: _____

Email Address: _____

Alfred Sandringham Caulfield

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YOUR REQUEST:

I request access to: all part of my Medical Record.

If *partial* access is required describe clearly the documents you want:

Please indicate if you wish to receive a scan of radiology results Yes / No

Approximate Dates:

I want to inspect the document(s) Yes/No

I want a copy of the document(s) Yes/No

Payment

A **\$23.40** application fee is payable upon submission of this application. **(DSS or Health Care Cardholders are exempt from this fee)**. In addition I understand that further charges may be made in respect of this request and that I will be supplied with a statement of charges prior to documents being copied.

	Cheque	
	Credit Card	Type: Visa Mastercard.....Diners Amex Other
		Cardholder Name:
		Expiration date
		Card No
		Amount:
	Cash	Must be delivered by hand. No responsibility can be taken for cash sent by mail
	Exemption (if applicable - see above)	Attach a photocopy of healthcare/pension card

Checklist

Before sending ensure the following have been attached

	Appropriate identification (required of all applicants seeking patient information)
	Evidence of relationship to patient or authority from patient if the applicant is not the patient
	Application fee (unless exempt)
	Evidence of grounds for exemption from application fee

Signature:

Date:

Please return the signed and completed Application form to the relevant address:

FOI Officer, The Alfred, PO Box 315, Prahran, VIC 3181

FOI Officer, Caulfield Hospital, PO Box 315, Prahran, VIC 3181

FOI Officer, Sandringham Hospital, 193 Bluff Road, Sandringham VIC 3191

All requests will be processed within the 45 days prescribed by the Freedom of Information Act, 1982