Austin HEALTH

FOI Amendment Application

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ..……..……

AFFIX PATIENT LABEL HERE

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 *(if preferred method of communication)*.....

Relationship to patient…….....

Details of Amendment

The document/s described below contain/s information that is:

Please tick ☐ Incomplete ☐ Incorrect ☐ Out of date ☐ Misleading

List the documents here…….....

……..…

……..…

…..……

Describe what information requires changing and why.....

……

……..…

……

.....……..

.....

……

Attached: *(Please tick)*

☐ Copies of relevant medical record documents that have been clearly marked

☐ Copies of other documentation that supports your claim

Austin HEALTH

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ..……..……

AFFIX PATIENT LABEL HERE

FOI Amendment Application

Authority to Amend a Medical Record

Request Relating to Your Own Medical Record

Signed ……..…… Date …..……/……..…/…….
(Applicant/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 make this request. 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 make this request. Any additional information can be provided in the space below.
- In relation to a deceased patient, the right to make this request by the most senior available next of kin is not guaranteed. To assist us in assessing your application and making an informed decision, please explain why believe your request is reasonable.

I, ……..……of……..…..
(Patient or Next of Kin) *(Address)*

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

to the aforementioned applicant.

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

Additional Information:

……

……

……..

……..

Specify the evidence provided (e.g. Death Certificate) .....

Send application to:

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

OR **Email:** foi@austin.org.au

Telephone: +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

Freedom of Information
Mount Street Offices: 86-92 Mount Street
PO Box 5555
Heidelberg, VIC 3084, AUSTRALIA
Telephone: +613 9496 3103
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*	$