Austin HEALTH

FOI Application FY 24/25

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ..……..……

AFFIX PATIENT LABEL HERE

Patient Details

Surname……**Given Names**……..……..……..

Date of Birth……**Best Contact Number** ……

Address……..……..…….

Email Address ……..…..

Applicant (if different from above)

Surname……**Given Names**……..……..…

Address……..……...

Best Contact Number ……**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 (Please tick any options that apply)

☐ 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

Please provide description of documents / dates you require if you ticked Part of Medical Record……..…

……

……..…

……

……

3) Do You Require Pathology and Radiology Results?

☐ No ☐ Yes If Yes specify date range:_____

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

<u>Please note:</u> There may be additional charges applied depending on the Type of Access required. This is in addition to the initial $32.70 Application Fee. Please refer to ***'Other Access Charges that may apply'*** within the Patient Information Form for further information on these charges.

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

*Confirm Email address for One Drive: ……..……

☐ I wish to obtain a DVD copy of the documents via Registered Post

☐ I wish to view the documents

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AFFIX PATIENT LABEL HERE

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, Mount Street Office
PO Box 5555
Heidelberg, VIC 3084

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

Enquiries: +613 9496 3103 **Office Hours:** 8am – 4pm

Austin HEALTH

Australian Business Number (ABN): 96 237 388 063

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

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

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.

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	$

Please note: Due to the nominal fee, **no further receipts** will be issued on these payments. For your own proof of payment/receipt purposes, please retain a copy of this form as this document becomes your tax invoice/receipt.

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*	$