

# FREEDOM OF INFORMATION APPLICATION

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UR Number: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Affix Hospital ID Label If Available



### Patient Details

Surname	Given Name(s)
Address	
Phone (home)	Phone (other)
Date of Birth	UR No. (if known)
Email address	

### Applicant Details (if different from above)

Surname	Given Name(s)
Address	
Phone (home)	Phone (other)
Email address	
Relationship to patient	Attach copy of any relevant legal documents (e.g. guardianship order)

### Complete this section if seeking access to a medical record other than your own

#### Patient competent

I, \_\_\_\_\_ of \_\_\_\_\_  
(Name of Patient) (Address)

authorise the Applicant identified above to access the documents identified below from my confidential medical record held by Eastern Health

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of Patient)

#### Patient not competent - e.g. child, advanced dementia, severe brain injury

Patient not competent to consent → go to 'Documents Requested' section

Attach copy of any relevant legal documents (e.g. Power of Attorney, Guardianship order)

#### Deceased patient - Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you the deceased patient's senior next of kin?

YES → go to 'Documents Requested' section

NO → Does the deceased patient's senior next of kin freely consent to you accessing the patient's confidential medical record?

I, \_\_\_\_\_ of \_\_\_\_\_  
(Deceased patient's Next of Kin) (Address)

authorise the Applicant identified above to access the documents identified below from the deceased patient's confidential medical record held by Eastern Health

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of deceased patient's Next of Kin)

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### Documents Requested

- Emergency Department attendance dated \_\_\_\_/\_\_\_\_/\_\_\_\_
- Admission dated \_\_\_\_/\_\_\_\_/\_\_\_\_
- Part of medical record (please specify) \_\_\_\_\_
- Outpatient notes dated \_\_\_\_/\_\_\_\_/\_\_\_\_
- Radiology/ Pathology results dated \_\_\_\_/\_\_\_\_/\_\_\_\_
- Complete medical record
- Time of Birth → Provide details of baby's mother: (1) Maiden name \_\_\_\_\_  
(2) Married name \_\_\_\_\_ (3) Date of birth (of baby's mother) \_\_\_\_/\_\_\_\_/\_\_\_\_

### Site/s or Services Attended

- Angliss Hospital
- Peter James Centre
- Yarra Ranges Health
- Spectrum
- Blackburn Public Surgical Centre
- Box Hill Hospital
- Wantirna Health
- Upton House
- Martin Luther Homes
- Maroondah Hospital
- Healesville Hospital & Yarra Valley Health
- Turning Point Drug and Alcohol Service
- Eastern Centre Against Sexual Assault
- Other \_\_\_\_\_

### Additional Information

### Type of Access Requested

Information will be sent electronically via secure portal unless a paper copy or CD is requested. Please tick below for alternate access.

- Photocopy (if available - see note above)
- Time of Birth letter (for time of birth request)
- View the original documents
- Copy on CD (if available - see note above)

### Fees and Charges

#### Application Fee

A \$32.70 application fee must accompany this form before the processing of this request can start. For waiver of the fee, provide a photocopy of your valid Health Care Card or Pension Card or other evidence of hardship.

#### Access Charges

In addition to the application fee, the following access charges may apply. If applicable, you will be notified of the relevant charges, which must be paid before you can access the documents. Do not pay these charges now.

CD	\$10.00
Photocopying	20 cents per page copied
Search Fee <i>(not applicable if requesting own records)</i>	\$24.50 per hour or part thereof
Viewing record <i>(if applicable)</i>	\$6.10 per quarter hour (under supervision)



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### Payment Methods (for application fee \$32.70)

#### Direct Deposit

Account Name: Eastern Health  
BSB: 083-153  
Account No: 5152 64726  
Bank: National Australia Bank, Box Hill  
3128 Vic  
Ref: Eastern Health patient number

#### Cheque - Make cheque payable to "Eastern Health"

**Cash** -Payable at Cashier Office between 8:30am and 4:00pm. Do not post cash.

#### Credit Card Type

Visa  MasterCard  Other (specify)

Name on card

Card number

Expiry Date

CVV

### FOI Application Completion Checklist

- Complete all relevant sections of this form, including signature and date below
- Include \$32.70 application fee OR copy of applicant's valid Health Care Card or Pension Card (for fee waiver)
- Attach Applicant's photo identification (e.g. copy of driver's licence or passport)
- Attach copy of any relevant legal documents (e.g. Power of Attorney, Guardianship order, Family Court order, Death Certificate)

Return completed application to the FOI Service at Eastern Health via:

Email: [foi@easternhealth.org.au](mailto:foi@easternhealth.org.au) (preferred option)

#### OR

Postal address: EH FOI Service  
Health Information Services  
Maroondah Hospital  
PO BOX 135  
Ringwood East VIC 3135

#### OR

Fax: (03) 9871 1653

#### Please Note:

- Your application will be processed in accordance with the Victorian FOI Act.
- If your request is not clear or you have not provided the necessary supporting documents we will contact you.
- Your information will be used to process this request and will be handled in accordance with Victorian privacy laws.
- We have 30 days to send a decision from the date a valid request is received. Extensions may apply.
- You do not have a right to access documents that fall within one of the 'exemption' categories in the FOI Act.
- Any documents released to you will be sent via electronic transfer or where applicable, registered post.

If you have any queries, please contact the FOI Service on (03) 9871 3170

Applicant's Signature  
*(Sign after printing)*

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

FOI APPLICATION EH 274600