



ADOPTION MEDICAL RECORDS APPLICATION

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: ____/____/____ Sex: M / F

Affix Hospital ID Label If Available



Applicant Details

Surname:			
Given Names(s):			
Date of Birth:	/	/	
Relationship to Baby:	Self <input type="checkbox"/>	Birth Mother <input type="checkbox"/>	Other <input type="checkbox"/>
Address:			
Mobile Number:		Home Phone:	
Email Address:			
Applicant Signature:		Date:	/ /
Photo Identification Provided:	Driver's Licence <input type="checkbox"/>	Passport <input type="checkbox"/>	Other <input type="checkbox"/>

Birth Mother Details

Birth Mother's Surname (at time of birth):		Given Name(s):	
Birth Mother's Given Name(s) (at time of birth):			
Birth Mother's Maiden Name(s) (if known):		Phone (Other):	
Birth Mother's Date of Birth:	/ /	Baby's Date of Birth:	/ /
Photo Identification of Birth Mother or Baby (as adult):	Same as Applicant <input type="checkbox"/>	Driver's Licence <input type="checkbox"/>	Passport <input type="checkbox"/>
	Other <input type="checkbox"/>	_____	

Hospital Details

Box Hill Hospital <input type="checkbox"/>	Angliss Hospital <input type="checkbox"/>
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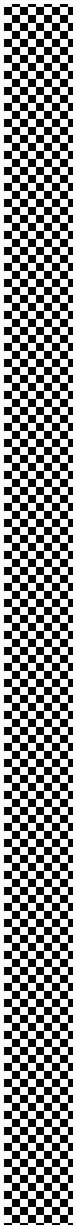
FOI Application Completion Checklist

Please return completed application form to the FOI Service at Eastern Health via:

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

Postal Address: EH Freedom of Information Service
Health Information Services
Maroondah Hospital
PO BOX 135
Ringwood East VIC 3135

Fax: (03) 9871 - 1653



FOI APPLICATION EH 274600