Eastern Health

FREEDOM OF INFORMATION APPLICATION

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*)

FOI APPLICATION EH 27600

FEH27460OG

Eastern Health

FREEDOM OF INFORMATION APPLICATION

UR Number: _____

Surname: _____

Given Name: _____

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

Affix Hospital ID Label If Available

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	☐ Box Hill Hospital	☐ Maroondah Hospital
☐ Peter James Centre	☐ Wantirna Health	☐ Healesville Hospital & Yarra Valley Health
☐ Yarra Ranges Health	☐ Upton House	☐ Turning Point Drug and Alcohol Service
☐ Spectrum	☐ Martin Luther Homes	☐ Eastern Centre Against Sexual Assault
☐ Blackburn Public Surgical Centre		☐ 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 $31.80 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 (*not applicable if requesting own records*)	$23.85 per hour or part thereof
Viewing record (*if applicable*)	$5.95 per quarter hour (under supervision)

FOI APPLICATION EH 27600

FEH27460OG

FREEDOM OF INFORMATION APPLICATION

UR Number: _____

Surname: _____

Given Name: _____

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

Affix Hospital ID Label If Available

Payment Methods (for application fee $31.80)	
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 $31.80 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 (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 27460O

FEH27460OG