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| BCH Bass Coast Health | **BASS COAST HEALTH**<br>**FREEDOM OF INFORMATION ACT**<br>**ACCESS REQUEST FORM** | ORG-012 |

**INFORMATION FOR APPLICANTS**

Under the terms of the *Freedom of Information Act 1982* (Vic), provision is made for members of the public to access patient records held by public Health Services. Patients (or Next Of Kin in certain circumstances) are entitled to apply to read records or alternatively obtain a copy. Should a patient wish to access information from our records the form below must be completed, in accordance with the terms of the *Freedom of Information Act 1982 (Vic)*.

Please complete and return this form to the Freedom of Information Officer:
Email: BCH.ROI@basscoasthealth.org.au Enquiries: Phone 03 5671 3154
Post: Bass Coast Health, PO Box 120, Wonthaggi Vic. 3995,

**PATIENT DETAILS -** *Please provide supporting documentation if you are applying for another person's information i.e. copy of Power of Attorney/Executor/ Birth Certificate.*

Surname..... Given Name(s) .....

Previous Surname (if applicable) ..... Date of birth ...../...../.....

Address ..... UR number (if known) .....

Suburb ..... State ..... Postcode.....

Telephone (home) ..... Telephone (mobile) .....

Email.....

**APPLICANT (if different from patient)**

Surname ..... Given Name(s) .....

Address ..... Suburb .....

State ..... Postcode..... Telephone (Home) .....

Email..... Telephone (mobile) .....

☐ **IDENTIFICATION** Copy of photo identification that shows your signature is **mandatory**, current driver's license/passport is acceptable.

☐ **APPLICATION FEE $32.70** (non-refundable) must accompany the written FOI request.

The Application Fee is **waived** if one of the following applies:

- Health Care Card or Pension Card (photocopy both sides)
- Compassionate grounds, i.e patient is deceased , authority from Next of Kin is required.

**INFORMATION FROM THE MEDICAL RECORD**

Reason for requesting information: .....

☐ Entire Medical Record

Or

☐ Part of the Medical Record, *please specify the information you require, e.g. admission date 15/10/2016 discharge date 21/10/2016*

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☐ I request a copy of the document(s)

☐ I request an inspection of the documents(s)

**AUTHORTY to release medical records**

I give consent to the Freedom of Information Officer to release the requested information to the listed applicant.

Signature of person consenting: ……..

Date: ……../……../……..

- In the instance where the patient is deceased, are you the patient's senior next of kin (SNOK)?
  ☐ Yes ☐ No
- In the instance where the patient is underage or incapacitated, are you the Power of Attorney (POA)/Legal Guardian/SNOK?
  ☐ Yes ☐ No if YES, please provide documentation e.g. Court orders/Power of Attorney to support this)
- If no to any of the above, patient/SNOK to complete consent above.

**ACCESS CHARGES**

When the medical record has been located, we will send you a letter advising the access charges

- Search & Retieval - $20.00
- Medical Record - Paper medical record 20 cents per page
- Postage - Postage (registered post) $10.50

*I acknowledge and agree to pay the above costs. I understand that the Freedom of Information Officer has up to 30 days to make a decision regarding this request, but in accordance with the Freedom of Information Act this period may be extended by not more than 15 days in order to consult with third parties that are the subject of the requested information, or in any case by a period of not more than 30 days where I agree. As stated under the Freedom of Information Act, requests may be denied if deemed to be too voluminous, and in that case I will be given an opportunity to consult with Bass Coast Health regarding the size and form of the request.*

FOI Applicant's Name: …….. Signature: ……..

**OFFICE USE ONLY**

Patient UR number: …… ☐ FOI Spreadsheet Updated:

Date Application Received: ……../…….. /…….. ☐ FOI request filed in MR:

Date FOI request finalised: ……../…….. /……..

Date Applicant advised of changes, additional information required: ……. /……. /…….

**Reviewed and approved by**: ☐ CEO ☐ CMO ☐ Quality ☐ Health Information Manager

Name: ……

Signature: …… Date approved: ……../…….. /……..

Date document posted / collected: ……. /……. /……. Document Viewed: ☐ YES ☐ NO

Date: ……../…….. /……..