Use this form to request access to documents held by our organisation, Central Gippsland Health (CGH).

Please complete the form and return it to:

**Email:** **foirequest@cghs.com.au** **or Mail: The Freedom of Information Officer**

**Central Gippsland Health**

**155 Guthridge Parade**

**Sale, VIC 3850**

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| **Section 1. Your Details** |
| Given Name(s): |   | Surname: |   |
| Date of Birth: |   | Email:  |   |
| Address:  |    |
| Suburb:  |   | Postcode: |   |
| Telephone:  |   | Mobile:  |   |
| Your relationship to the Patient  |
| [ ]  Self – go to **section** 4**. Documents Requested** | [ ]  Parent | [ ]  Legally responsible person |
| [ ]  Lawyer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  [ ]  Other . |

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| **Section 2. Patient Details - complete this if you are requesting access to documents about another person**  |
| Patient name:  |  |
| Date of Birth: |  | Email: |  |
| Address:  |  |
| Suburb: |   | Postcode: |  |
| Telephone: |  | Mobile: |  |
| If you are applying for access to another person’s records you will need to provide:* Consent from the patient, or;
* Identification that you are the senior next of kin to the patient, or;
* Written authorisation from the senior next of kin
1. Does the patient freely consent to you accessing their confidential medical record?

[ ]  YES – go to **section 3. Consent**[ ]  NO – get consent from the patient 1. If the patient is deceased: Date of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you the deceased patient’s senior next of kin?

[ ]  YES – go to **section 3. Consent**[ ]  NO – go to next point (4) below1. Does the deceased patients senior next of kin freely consent to you accessing the patient’s confidential medical record?

[ ]  YES – deceased patients senior next of kin to complete **section 3. Consent**[ ]  NO – get consent from the senior next of kin |

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| **Section 3. Consent** |
| You must obtain the appropriate consent for Central Gippsland Health to release information. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Name of Patient or senior next of kin) (Address)* Give consent for Central Gippsland Health to release information from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Name of patient)* Medical records to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Name of applicant)* Signature of person consenting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Section 4. Documents Requested** |
| **(1) Campus Attended:**  |
| [ ]  CGH Consulting suites   | [ ]  Heyfield Hospital  | [ ]  Loch Sport community Health  |
| [ ]  Maffra Hospital | [ ]  Rosedale Community Health | [ ]  Sale Hospital  |
| **(2) Documents requested:**  |
| [ ]  Complete Allied Health record **OR**  | [ ]  Complete Community record  | [ ]  Complete medical record  |
| [ ]  Emergency Department attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Outpatient notes dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Part of medical record: Dates from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Radiology/Pathology results dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Birth Registry request - Provide details of baby’s mother  Maiden name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Married Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (of baby’s mother): Click or tap to enter a date. |
| [ ]  Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Section 5. Collection of Information**  |
| How would you like to receive a copy of the information?[ ]  Collect in person [ ]  send by Registered Mail   |

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| **Section 6. Fees and charges**  |
| It will cost **$29.60** to apply for these documents. (Healthcare Card and Pension Card holders may be exempt from this fee upon proof of identification). Access Charges: In addition, the following charges may apply. If applicable you will be notified of the relevant charges and payment methods, which need to be paid before the documents are provided.  |
| Photocopying  | $0.20 cents per A4 page copied |
| Postage Charges  | $6.00 |

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| **Section 7. FOI Application Checklist**  |
| Before submitting your application please make sure you complete the following: [ ]  All relevant sections of this application form **Application Fee:**  |
| [ ]  Payment of the application fee ($29.60) is included OR | [ ]  A copy of valid Healthcare card/Pension Card  |
| [ ]  Applicants photo identification  |
| **Identification:** Copy of your photo identification  |
| [ ]  Birth Certificate  | [ ]  Driver’s Licence  | [ ]  Passport  |
| **Evidence of relationship to patient:**    |
| [ ]  Authorisation from patient in **section 3. Consent**  |
| [ ]  Custody OR [ ]  Parenting orders OR [ ]  Family violence intervention orders If the person is subjected to a current family violence order, conditions of the order must be provided |
| [ ]  Legal Guardian Order  |
| [ ]  Power of Attorney (POA - only required if this has not already been provided to CGH) |
| [ ]  Senior Next Of Kin  |
| Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Office Use Only**  |
| FOI reference number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Application fee paid [ ]  Application fee waived  | Date Valid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |