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**](mailto: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) below   1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |