

Freedom of Information Application Form



Please read the **Information Guide** before completing this form

Patient Details

First Names.....Surname.....

Date of Birth..... Patient UR number (if known)

When the patient is aged 16 and over it is preferable for them to apply for access to their own medical records, or signed authorisation from the patient is required. (See over 5)

Applicant Details

Mr/Ms..... First Names..... Surname.....

Address.....

Suburb State Postcode

Phone Number (home) (mobile)

Relationship to Patient (self/parent/other)

Information Requested from the medical record

Photocopy of the medical file (UR) (20c per page)

Photocopy of part medical file (UR) (20c per page). Please specify

Other
.....
.....
.....

Photographs

Copy of photographs (\$2.00 per print) this may vary on the age of the negatives

Photographs provided on CD (\$20.00 per CD) for digital prints taken from April 2002 onwards

Medical Imaging / Xrays /Scans

These can be obtained directly from our Medical Imaging Department. T: 9345 4634

Application Fee (non-refundable) **MUST** be sent with this form

\$24.40 cheque, money order or credit card made payable to The Royal Children's Hospital

If one of the following applies to you, the application fee is waived:

Health Care Card or Pension Card (photocopy of both sides)

Compassionate grounds e.g. patient is deceased

Photographs only

Identification

Photocopy of identification that shows your signature, for example, driver's licence, passport

Court Orders please enclose a copy of any relevant family court order with your application.

APPLICANT'S SIGNATURE.....Date

Please complete the following section if seeking access to a medical record where the patient is aged 16 and over.

I, of
(Patient) (Address)

do hereby authorise The Royal Children's Hospital to release information from my medical records to the
aforementioned applicant.

Signed Date
(Patient)

Enclose photocopy of identification that shows a signature, eg driver's licence, student card, health care card

**Please complete the following section if seeking access to a medical record other than your own.
Where the patient is deceased, the patient's next of kin must sign the authorisation.**

I, of
(Patient or Next of Kin) (Address)

do hereby authorise The Royal Children's Hospital to release information from
..... medical record to the aforementioned applicant.
(Patient's Name)

Signed Date
(Patient/Next of Kin signature)

Enclose photocopy of identification that shows a signature eg. driver's licence, passport

Please return applications to:

Freedom of Information Office
The Royal Children's Hospital
50 Flemington Road
Parkville Victoria 3052

T: 9345 5156 or 9345 5132
F: 9345 4088
E: foi@rch.org.au