

Freedom of Information application form

Please read the **ACCESS TO MEDICAL RECORDS - Information Guide** before completing this form

PATIENT

First names Surname

Date of birth/...../..... Patient UR number (*if known*)

If the patient is aged 16 and over and **not** the applicant an authority to release will be required please see page 2.

If there are current Family Court Orders in place, a copy of the order should be provided.

APPLICANT

Mr/Ms/Miss/Mrs First name..... Surname

AddressSuburb

State PostcodeTelephone (home) (mobile)

Relationship to patient (self/parent/other)

IDENTIFICATION Copy of photo identification that shows your signature is **mandatory**
We accept current driver's licence/passport

APPLICATION FEE \$28.90 (non-refundable)
Methods of payment - See the [Information Guide](#) or [Application Fee payment form](#)

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

- Health Care Card or Pension Card (photocopy both sides)
- Compassionate grounds (patient is deceased)
- Photographs only

INFORMATION FROM THE MEDICAL RECORD

ENTIRE MEDICAL RECORD OR PART OF THE MEDICAL RECORD
(SPECIFY THE INFORMATION YOU REQUIRE)

.....
.....
.....
.....

PHOTOGRAPHS (*no application fee required when the request is for photographs only*)

X-RAYS/SCANS IMAGES are not provided with the medical record, these can be obtained directly from
RCH Medical Imaging Department Tel 9345 6777 Email: medical.imaging@rch.org.au

APPLICANT'S SIGNATURE _____ **Date** ____ / ____ / ____

AUTHORITY TO ACCESS INFORMATION where the Applicant is NOT the patient

(Indicate which of the following applies to your application)

Request for medical records relating to a patient over 18yrs of age

The patient **must** sign the below authorisation **or** you must provide evidence that you have the authority to access this information. (eg Power of Attorney (Medical), or guardianship documents)

Request for medical records relating to a patient 16 – 18 yrs of age

In recognition of a young person's evolving competence and right to privacy, the RCH policy is to obtain consent from the young person. The patient must sign the below authorisation or you must provide evidence that the young person is not competent to provide authority. Include copy of patient identification.

I, _____ of _____
(Patient) (Address)

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

_____ Date ____/____/____
(Patient signature)

Enclose copy of associated documents

Patients Identification, eg driver's licence/passport/student card

Power of Attorney (Medical) or Guardianship documents

ACCESS CHARGES

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

- **Electronic Medical Record**
 - Disc \$20.00 - \$50.00
- **Paper records:**
 - Photocopy 20 cents per page
- **Photographs**
 - Disc - \$20.00
 - Print - \$2.00 each
- **Postage** (registered /parcel post) \$10.00
(this may increase depending on the size of the package)

Submit your Completed FOI Application to:

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

Email: foi@rch.org.au

In person: Family Hub, ground floor

Facsimile: 9345 4088

Enquiries: 9345 5156/9345 5132