

PATIENT DETAILS

First Name	Last Name
Previous Name	Date of Birth
Email Address	Contact Number/s
Postal Address	Suburb
State / Territory	Postcode

If you are requesting your records, a copy of your current photo ID (eg Driver's License, Passport) with signature is required.

☐ **TICK IF YOU ARE REQUESTING ON BEHALF OF ANOTHER PERSON**

Please provide your details:

First Name	Last Name
Email Address	Contact Number/s
Postal Address	Suburb
State / Territory	Postcode
Relationship to Patient	

AUTHORITY FOR A REPRESENTATIVE TO ACT

Please provide additional supporting documentation:

Copy of representative's personal identification; and

Patient's written authorisation below.

I, [name] _____ give permission and authorisation for my representative to act on my behalf and have access to any information requested.

_____ Patient Signature _____ Date

If there is no Authority please provide evidence of other legal documents e.g. Enduring Power of Attorney, VCAT order, Appointment as Guardian etc.

If the patient is deceased, please provide:

- The written authorisation of the person's senior available next of kin
- Proof the senior available next of kin is over 18 and,
- A copy of the death certificate.

DESCRIBE THE DOCUMENTS YOU ARE REQUESTING

Please tick

<input type="checkbox"/> Date Range	From	To
<hr/>		
<input type="checkbox"/> Discharge Summaries	(where available provided at no cost)	
<hr/>		
<input type="checkbox"/> Clinical Notes / Progress Notes		
Includes Emergency Department notes, operation reports, anaesthesia records, outpatients and mental health notes		
<hr/>		
<input type="checkbox"/> Radiology Images	(includes X-rays, CT scans, MRIs, Ultrasound, PET scans, etc)	
<hr/>		
<input type="checkbox"/> Radiology reports		
<hr/>		
<input type="checkbox"/> Outgoing Clinical Correspondence		
<hr/>		
<input type="checkbox"/> Mental Health Assessments		
<hr/>		
<input type="checkbox"/> Medication Records		
<hr/>		
<input type="checkbox"/> Include records prior to 2016	(Paper History - stored offsite – attracts extra charges)	
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You can give more detail here:

Form of Access: *(tick one)*

- ☐ Emailed Secure document *(preferred)* OR
- ☐ Posted Paper documents *(incur extra charges)*

All documents are reviewed in accordance with the Freedom of Information Act 1982 (Vic). Some documents may require redactions. If you are not willing to receive a copy of a redacted document, the document will not be released, and the application denied.

Are you willing to receive redacted documents?

☐ Yes OR ☐ No

FEES AND CHARGES

Application fee:	\$32.70 (non-refundable)
Search and Retrieval fee (off-site):	\$24.50
Electronic Medical Record pages (PDF):	\$0.05 per page
Paper file (copied or scanned) pages:	\$0.20 per page
Radiology Images (via link)	\$22.00 per link
Medical Photography (USB):	\$22.00 per USB
Printed records per page:	\$0.20 per page
Postage charges:	\$11.00 registered mail
Inspection / Supervision charge:	\$6.10 per quarter-hour or part thereof

A valid application requires payment of the application fee. As your application is processed, additional charges may apply calculated in accordance with the schedule listed above. If additional charges apply, we will invoice you as the request is processed.

If you have a Concession Card:

The application fee is waived if you provide details of your pension or healthcare card. However, production (photocopying, CD, link etc.) costs may still apply. Please ensure you attach a copy of your pension or healthcare card to your request.

SIGN THE APPLICATION

I understand that charges may apply under the Freedom of Information Act 1982 (Vic) and that I will be supplied with an invoice for applicable fees and charges. I also understand that I have to supply proof of identification.

_____ Applicant's Signature _____ Date

CHECKLIST FOR APPLICATION

Please ensure that you include the following with your application.

- This Application form with your signature
- A Copy of the Photo Identification
- Patient consent or proof of Senior next of kin (for applications by those who are not the patient)
- Application fee
- Pension or Healthcare Card (if applicable)

Please email signed application form with proof of identification to foirequest@mh.org.au.

PAYMENT

Please do not send your credit card details via email – it is not a secure method of communication.

☐ Cheque☐ Money Order☐ Credit Card – complete details below☐ Visa☐ MasterCard

Cardholder name: _____ Exp ____/____

Card number:

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Signature: _____ Amount \$ _____

PLEASE RETURN APPLICATION AND PAYMENT TO

ATT: Freedom of Information Officer

The Royal Melbourne Hospital

C/- Post Office

Royal Melbourne Hospital, 300 Grattan St PARKVILLE VIC 3050

Phone (03) 9342 7224 Fax (03) 9139 3000

Email: FOIrequest@mh.org.au

What is the Freedom of Information process?**Approval Process**

All health records undergo review prior to release. Approval for release will be sought only after that review, applicable fees are paid and valid authority provided. If the medical records are not your personal records, you must include the authority of the patient (or if deceased, their senior next of kin).

Notification of Approval

We will notify you by email of our decision, usually within 30 days of receipt of payment of the application fee (unless further time is allowed by the FOI Act).