Freedom of Information Application

Please Send form to:

Medical Records Officer,
PO Box 42
Omeo Vic 3898

Enquires: Phone 5159 0100
reception@omeohs.com.au

DATE: ____/____/____ **Patient UR: _____**

Patient Details: Please provide supporting documentation if you are applying for another person's information i.e. copy of Power of Attorney/Executor/ Birth Certificate.			
Surname:		Given name(s):	
Address:			
Date of birth:		Email:	
Telephone:		Mobile:	
Applicant Details: (If different from patient)			
Surname:		Given Name:	
Address:			
Date of Birth:		Email:	
Telephone:		Mobile:	

Patient/Senior Next Of Kin (SNOK)Consent:

I give consent for the Freedom of Information Officer to release the requested information to the listed applicant.

Signature of person consenting: _____

- In the instance where the patient is deceased, are you the patient's senior next of kin (SNOK)?

  Yes ☐ No ☐
- In the instance where the patient is underage or incapacitated, are you the Power of Attorney (POA)/Legal Guardian/SNOK?

  Yes ☐ No ☐ (if yes, please provide documentation eg: Court orders/Power of Attorney to support this)
- If no to any of the above, patient/SNOK to complete consent above.

Proof of Identity (Please provide a copy of one of the following forms of identification):	
☐ Passport	☐ HealthCare Card
☐ Drivers License	☐ Birth Certificate
☐ Medicare Card	☐ Other

Information Required:	
☐ I would like a copy of the information	☐ I would like to inspect records
☐ Surgery / Medical	☐ Emergency
☐ Maternity	☐ Allied health
☐ Rehabilitation	☐ Community Health
☐ Aged Care	☐ Radiology
☐ Birth Registry Request *(Require Mother's Surname, date of birth and Mother's Signed Consent completed over page).*	☐ Pathology ☐ Other _____
Date(s) of patient attendance to hospital:	
Reason for Requesting Information: (assists us to provide you with the most relevant information)	

Consent:

Application fee (non-refundable) $27.20
Search and retrieval fee $13.60
Photocopying of A4 page 20c per page

Fees are waived on presentation of a Health Care or Pension card

I acknowledge and agree to pay for the above costs associated with this request. I understand that the Freedom Of Information Officer has up to 45 days to respond to this request. I also understand that my documents will be sent via normal mail unless I choose to pay $7.50 for registered post. Requests may be denied if deemed to be voluminous as stated under the Freedom of Information Act. I agree to revise the size of requested information if necessary.

FOI Applicant's Signature: _____

OFFICE USE ONLY:

Medical Records Staff Member releasing Information

_____Signature_____

Date Sent: ___/___/___ FOI Spreadsheet Updated ☐

Reviewed and approved by: ☐ **CEO** ☐ **DMS(if applicable)** ☐ **DC(N)&CS (if applicable)**

Quality notification & date ☐ ____/____/____