Queen Elizabeth Centre
53 Thomas Street
Noble Park VIC 3174
T: 03 9549 2777
F: 03 9549 2779
Email: theqec@qec.org.au
Website: www.qec.org.au
ABN: 23 237 300 347

1.4.5 FREEDOM OF INFORMATION

Access Request Form – (FORM 1008)

HOSPITAL RECORD

I wish to obtain the following information - Please list the information required:

Approximate year of contact with QEC: [ ]

ACCESS TO QEC RECORDS OF: (Please supply CLIENT/PATIENT DETAILS)

SURNAME ______________________________

GIVEN NAME ______________________________ DOB ___ / ___ / ________

Current Street Address ______________________________

SUBURB ______________________________ POSTCODE ______________

Email Address ______________________________

Home Tel: ______________ Work Tel: ______________ Mobile: ______________

REQUESTOR DETAILS (If you are not the client requesting details)

COMPANY/ORGANISATION NAME (If applicable) ______________________________

Given Name & Surname ______________________________ DOB ___ / ___ / _____

Current Street Address ______________________________

SUBURB ______________________________ POSTCODE ______________

Email Address ______________________________

Home Tel: ______________ Work Tel: ______________ Mobile: ______________

What is your relationship to the client? ______________________________

PLEASE NOTE: **All applications must be accompanied with PROOF OF IDENTITY for the REQUESTOR**:

- One photocopy of photo identification:
  - Driver's Licence; or
  - Passport
- If Photo ID is not available then 3 other forms of ID are required i.e.
  - Medicare Card
  - Birth Certificate
  - Credit Card or EFTPOS Card (or any other card that provides your name)
- Mandatory FOI application fee of $25.10

Please note this application will not proceed without this payment. You will be notified if the photocopying fee exceeds $25.10.

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1. Is the client deceased? YES / NO

If YES, are you the next of kin? YES / NO

2. In the event that the client is unable to make an informed decision about him/herself, are you the Medical Power of Attorney/Legal Guardian? YES / NO

If NO to question 2 above, have you attached the client's written permission to obtain information on their behalf? YES / NO

NOTE: You may not have access to a client's medical record without the client's or next of kin's written consent. Please provide evidence if you are the Patient's next of kin or Medical Power of Attorney/Legal Guardian.

Please refer to the attached brochure for further information about your request for information. You will be invoiced for the photocopying charges via mail.

DECLARATION

I understand that my request will not become valid until the payment of $25.10 application fee has been made. Where the request has been made by a third party, I understand that the application fee and the client's written consent has been attached. I understand that further to the application fee that photocopying charges may apply in respect to the application and that the Freedom of Information Office has up to 45 days to respond to this request. You will be notified if the photocopying charge is going to be greater than $50.

Please note that your information will be sent to your address via surface mail once the photocopying invoice has been paid.

Signature ______________________ **Date** ___ / ___ / _________

OFFICE USE ONLY:

Date FOI Request Received ____/____/______

Date 45 days from Receipt of FOI Request: ____/____/______

Date entered onto electronic database ____/____/______

Application Fee Received: Please state Amount **YES / NO** **$** ____ . ____

Photocopy Fees (If Applicable) **$** ______ . ______

Date FOI Client Advised if cost will be >$50 Photocopying ____/____/______

Invoice No: for Photocopying

Date invoice raised ____/____/______

Date money received for photocopying ____/____/______

Date FOI client documentation and Invoice for photocopying sent to client: ____/____/______

Photo Identification sighted or attached: **YES / NO** **Print Name** **Signature**

Client files and request letter taken to Clinical Services Manager: **YES / NO** Date ____/____/______

Action Taken: ______________________

Signature: **Print Name:** ______________________

Date: ____/____/______

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