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**FREEDOM OF INFORMATION APPLICATION FORM**

Please complete the following details and return this form with:-

* Proof of identification (eg Photocopy of Driver’s licence)
* Application fee of $30.60
	+ Cash, EFTPOS and Credit Card payments can be made at Reception
	+ Direct Deposit to the CAH General Account with a Reference of FOI and your last name (BSB – 633000 Account No – 135859056)
	+ Fees can be waivered on the basis of hardship, please provide evidence which you believe supports your claim (eg Copy of your Health Care Card or Pension Card)

To: Freedom of Information Manager

 Colac Area Health

2-28 Connor Street

COLAC VIC 3250

Fax: (03) 5232 5472 or Email: healthinfo@cah.vic.gov.au

Please contact the Freedom of Information Manager on (03) 5232 5253 if you have any questions.

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| **Patient/ Client Details: (Please print details of the patient whose file is being requested)** |
| Name: | Click or tap here to enter text. |
| Did patient attend CAH under another name? If so, please specify: | Click or tap here to enter text. |
| Date of Birth: | Click or tap to enter a date. |
| Address: | Click or tap here to enter text. |
| Telephone:  | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |

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| **If you are not the patient to whom the request relates please provide your details below:** |
| Name: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Telephone: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Relationship to Applicant: | Click or tap here to enter text. |
| **Note:** Patient’s written consent must be attached. |

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| **Description of the documents you require: (Please be specific and include dates)** |
| Click or tap here to enter text. |

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| **Please indicate the method you wish to obtain the above information: (Please tick)** |
| [ ]  Obtain a copy [ ]  Please send via Registered Post or [ ]  I would like to collect them |
|  [ ]  Inspect (supervision fees apply) and obtain a copy |
|  [ ]  Inspect the originals (supervision fees apply) |

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| **Reason for request:** |
| Click or tap here to enter text. |

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| **List of Current Fees and Charges** |
| **Application Fee** | $30.60 |
| **Photocopying Charges** | $0.20 per photocopied page |
| **Supervision Charge** | $5.75 per quarter hour, or part there of |
| **Images to disc** | $25 |

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| **Authorisation:** |
| I understand that:* Charges may be made under the Freedom of Information Act in respect of this request and that I will be supplied with a statement of charges if appropriate.
* Colac Area Health has 30 days to process valid (complete) requests made under the Freedom of Information Act.
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| --- | --- | --- | --- |
| Signature: |  | Date: |  |
| [ ]  By ticking this box I confirm that I am the person named above and that I authorise the use of a digital tick box in place of my paper based signature.  |
| PRINT NAME:  | Click or tap here to enter text. |