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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](mailto:healthinfo@cah.vic.gov.au?Subject=Freedom%20of%20Information%20Application)

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. | | |