**APPLICATION FOR ACCESS TO DOCUMENTS**
(under Freedom of Information Act 1992, S.12)

**DETAILS OF APPLICANT**

Surname ...................................................... Given Names: ……….............................................

Australian Postal Address:....................................................................................................Postcode……………...

Telephone No. (Home)…….....................(Business)………...................Date of birth...................

Name of Organisation/Business: ……...............................Email Address:…………………………

*If application is on behal*f *of an organisation*

From which site/health service do you require the documents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you applying for information about another person? 🞐 Yes No 🞐**

If you answered **Yes,** please give details of the other person:

Surname ...................................................... Given Names: ……….............................................

Australian Postal Address:....................................................................................................Postcode……………...

Telephone No. (Home)…….....................(Business)………...................Date of birth...................

Your relationship to this person: ………………………………………………………………………

*If you are applying on behalf of someone else, you must provide original, current written consent signed by that person in addition to proof of identification for both parties. If the information relates to a deceased person, access will be granted to the person’s closest relative who is 18 years or older. Proof of this relationship is required generally in the form of a statutory declaration or death certificate.*

**DETAILS OF REQUEST**  Personal  Non-Personal (*Please tick)*

I am applying for access to document(s) concerning: (Attach further pages if required) .........................................................................................................................................................................................................................................................................................................................................

**FORM OF ACCESS**

I require a copy of the document(s)  Yes  No (*Please tick)*

APPLICANT'S SIGNATURE: ............................................................ Date …....../…....../……..

**NOTE THERE IS NO APPLICATION FEE OR CHARGE FOR PERSONAL INFORMATION**.

**COST (If applicable - i.e. NOT for Personal Information in your medical record)**

Attached is a cheque/cash to the amount of $30.00 to cover the application fee. I understand that before I obtain access to documents I may be required to pay processing charges in respect of this application and that I may be required to pay a deposit of 25% of the estimated cost of processing.

*An estimate of charges can be supplied upon request. In certain cases a reduction in fees and charges may apply - see section on fees and charges in attached notes. If you consider you are entitled to a reduction, submit a request with copies of documents which address the criteria on the back of this form and support your application for a fee reduction.*

I am requesting a reduction in fees and charges  Yes  No *(Please tick)*

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| --- | --- | --- | --- |
| **DOCUMENT** | **DESCRIPTION** | **YES** | **NO** |
| DISCHARGE SUMMARY |  |  |  |
| REGISTRATION FORM | Computer form with name, address, contact etc. |  |  |
| MENTAL HEALTH ACT REFERRAL/ADMISSION FORMS | Forms used for referral/admission as an involuntary patient |  |  |
| REFERRAL LETTERS |  |  |  |
| PROGRESS NOTES including:  | MedicalNursingPsychologySocial WorkOccupational TherapyPhysiotherapy | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| NURSING CARE PLANS, ASSESSMENTS & DISCHARGE PLANS |  |  |  |
| CORRESPONDENCE including: | Letters from youRelatives/friendsLegalOther doctors/hospitals | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| OBSERVATION CHARTSincluding: | AdmissionWeightDiet/fluid intakeBlood Pressure & Temp. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| TEST RESULTS including: | Blood testsX-raysCAT scansEEG / ECG | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| OTHER INFORMATION (PLEASE SPECIFY): |  |
|  |
|  |

I wish to have documentation relating to: MOST RECENT ADMISSION 

 ALL ADMISSIONS 

**HOW TO SUBMIT THE APPLICATION FORM**

Proof of identity will be required where applicants are seeking access to Personal Information. You will be required to provide such proof before access is given to documents containing Personal Information. Certified or notarised copies of identification will suffice. Most Pharmacies are able to certify ID for members of the public.

 **Applications may be lodged:**

|  |  |
| --- | --- |
| **By email:** FOI.GH@health.wa.gov.au | **By mail:**Area FOI CoordinatorGraylands HospitalPrivate Bag 1CLAREMONT WA 6910 |
| **By fax:** (08) 9385 2011 | **For further enquiries:** Ph: (08) 6159 6475 |