The Royal Women's Hospital Melbourne
Blood Group Request form
01/07/2020 – 30/06/2021

Please note: Blood group testing is not a standard test given to all patients, including babies born or treated here at the Royal Women's Hospital. Please contact Freedom of Information on (03) 8345 2610 to discuss your application or contact your GP who can perform the test for you.

SECTION 1 - APPLICANT DETAILS

Mr/Mrs/Miss/Ms/Dr Surname: ……………………….…….……... Given Names: ………….……………………………….……

Date of Birth: ………./………./………. Phone number(s) (H): ……..……………………..…. (M):……………..……………..…

Address: ………………………………………………………………………………..…….………………………………………...

Suburb: …………..………………..…. State: ……………..……………….………... Postcode: ….…………..………………………

Email: ……………………….……………………………………………………………….………………………………………….

* If we need to contact you to discuss your application, what is your preferred method of contact? (please tick)

☐ Phone/Mobile ☐ Email

SECTION 2 – RELATIONSHIP OF APPLICANT TO PATIENT/BIRTH MOTHER

☐ **N/A – Self (Please answer below 'adoption' question then go to Section 4)**

Is this in relation to an adoption? YES / NO (please circle)

If YES, please attach your birth certificate with original name issued before you were adopted, Birth Certificate issued with your current name after your adoption and any other documentation you have obtained from DHHS

NATURE OF RELATIONSHIP OF APPLICANT TO PATIENT/BIRTH MOTHER (please tick one):

☐ Parent of Child - Mother / Father (please circle) ☐ Child

☐ Other please specify: …………………………………………………………………………..……………………...

Please note: If you are applying for someone else's information, please provide consent and photo ID from the patient and documentation which clearly shows that you are related to the patient e.g. Birth Certificate, Marriage Certificate, Adoption paperwork and/or Death Certificate in addition to your personal ID (Refer to page 2).

SECTION 3 – PATIENT/BIRTH MOTHER'S DETAILS

Patient/Birth Mother's Surname: ………………………….…... Patient/Birth Mother's Given Names: ……..…………..………

Patient/Birth Mother's Maiden name: ………………………………………………………….

Other Names known as at the time of hospital presentation (if known and different from above):

………………………………………………………………………………………….……………….……………………..…...

Patient/Birth Mother's Date of Birth: ………./………./………

FORM OF ACCESS (please circle):

I would like a printed copy of my Blood Group Information to be sent by post (charges will apply) YES / NO
I would like a digital copy of my Blood Group Information to be sent by email (no charge) YES / NO

SECTION 4 – DETAILS OF REQUEST

In order for us to make an informed decision regarding your request, please tell us why are you wanting to access your Blood Group information e.g. personal use, family research, etc. (please specify):

……….

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SECTION 5 – AUTHORITY TO ACCESS INFORMATION:

I, the applicant, acknowledge that:

- My application will be processed in accordance with the Freedom of Information Act 1982 (VIC) and that I have provided valid authority
- Charges will apply under the *Freedom of Information Act 1982 (VIC)* to access blood group details and need to be paid in full before my application is processed
- Total charges to access this information will be $22.20 per application and I understand if I require a printed copy an additional cost will be incurred for postage
- I understand that fees will not be waived to access my Blood Group information even if I possess a Healthcare/Concession card
- The information and documents that I provide will be used to process my request and will be handled in accordance with the Victorian Privacy Laws
- RWH has 30 days to send my Blood Group information from the date a valid request is received (extensions may apply)

Applicant signature …….. Date: ……/……/…….

REQUEST FOR MEDICAL RECORDS RELATING TO ANOTHER INDIVIDUAL

- The individual must sign the below authorisation and you have to provide evidence that you have the authority to access this information on behalf of the individual. Any additional information can be provided in the space below
- If you are unable to obtain the proper consent from the individual, information that you receive may be redacted in accordance with the *Freedom of Information Act 1982 (Vic)*. To assist us in assessing your application and making an informed decision regarding the release of individual's time of birth information, please explain the purpose of your application in the 'additional information' field below and why you believe it is reasonable to release the records to you
- In relation to a deceased individual, access by the most senior available next of kin is not guaranteed. To assist us in assessing your application and making an informed decision regarding the release of a deceased individual's blood group information, please explain the purpose of your application in the 'additional information' field below and why you believe it is reasonable to release the information to you

I, …… Of ……..…..……
(Individual or Next of Kin) (Address)

hereby authorise The Royal Women's Hospital to release information about …….
(Individual/Myself)

to the applicant.

Individual/Next of Kin Signature …….. Date: ……/……/……

Additional Information:

……

……

……

……...

Supporting evidence provided (e.g. Death Certificate, Adoption Paperwork)……..……

……

…..……

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CHECKLIST INFORMATION – Please ensure that the following is submitted

- ☐ Completed Blood Group Application Form
- ☐ Completed payment slip
- ☐ Copy of Photo ID (e.g. Driver's licence, Passport, Key pass etc.)
- ☐ Copy of Birth Certificate (if applicable)
- ☐ If you have had a change of name, documentation to support this (e.g. Marriage Certificate, extract etc.)
- ☐ All Adoption paperwork (if applicable) including:
  - Birth Certificate with your birth mother's name and your original name issued before you were adopted
  - Birth Certificate issued with your current name after your adoption
  - Other documentation you have obtained from DHHS

FOR APPLICATIONS REGARDING THOSE WHO ARE NOT THE PATIENT (In addition to the above)

- ☐ Completed and signed by the Individual (who is not the applicant) 'Request for medical records relating to another individual' section
- ☐ The Individual's Photo ID
- ☐ Documentation to prove relationship (e.g. Birth Certificate, Marriage Certificate, etc.)

Please note: We may need you to provide additional supporting documentation but will contact you if this is required

ACCESS FEES AND CHARGES	
Search Fee	$22.20
Electronic Copy	
Blood Group Letter (sent via email)	No Charge
Post	
Postage (Registered within Australia)	$ As per Aust. Post
International Postage (Registered)	$ As per Aust. Post

PAYMENT

☐ Cheque ('The Royal Women's Hospital') ☐ Money Order ☐ Credit Card – Complete details below

Cardholder Name: _____ Application Fee Amount: **$22.20**

☐ Visa ☐ MasterCard Exp. Date: ……/……

Card Number: | | | | | | | | | | | | | | | |

Signature: _____

Please return (post or email): application, supporting documentation and payment to

Freedom of Information
Health Information Services
The Royal Women's Hospital
Locked Bag 300
Parkville VIC 3052
P: (+61 3) 8345 2610 **F**: (+61 3) 8345 2642
E: foi@thewomens.org.au