

**FREEDOM OF INFORMATION REQUESTS 1/7/2018 – 30/6/2019**

**FREEDOM OF INFORMATION ACT (VIC) 1982**

Dear Applicant,

Thank you for your enquiry regarding accessing information through Freedom of Information (FOI).

There are costs involved in providing information through FOI and these charges are:

1/7/2018 – 30/6/2019	
Application fee (non-refundable)	\$ 28.90
Search fee	\$ 21.70
Standard photocopying	\$ 00.20 (per page)
Colour Images	\$ 2.00
*Transport/Handling	\$ 15.00 (per record)
*CD – Radiology/Scans	\$ 10.00
*Postage (Registered – Australia)	\$ As per Auspost
*Postage (Overseas)	\$ P.O.A.

\*If applicable

Records between 1968 – 1995 are either on Microfilm/Microfiche and are required to be reproduced by an external party. All external costs associated with retrieving, handling and processing your request will be payable. An estimation of these costs will be provided to you in writing upon receiving your application and a deposit is usually required prior to proceeding.

**Please note:** If the records you are seeking are relating to a birth prior to 1960, please complete a Time of Birth request (not an FOI request form) as this is the only information available.

When your application form, application fee and certified ID has been received, a search will be made for the information you seek and you will be advised of the outcome. Under the FOI Act, an agency has 30 days to provide a response to the information that is being requested. In some cases, this may be extended by 15 days when third party consultation is required.

**Note:** Records will not be released to applicants appearing in person at the department, unless pre-arranged with the FOI clerk following confirmation that the records have been processed, copied and ready for collection. Same day service is not available.

Please complete the following application form and post it with a **certified photocopy of personal photographic identification** such as a Driver's Licence, Passport or keypass to:

Freedom of Information Clerk  
Health Records and Information  
The Royal Women's Hospital  
Locked Bag 300  
Parkville Vic 3052

Please provide a certified copy of your valid Health Care/Pension Card with your application for the application fee to be waived. All other charges are payable.

If you have any queries, please do not hesitate to contact **8345 2610**.

**Freedom of Information Clerk**  
Health Records and Information  
Ph: 8345 2610 Fax: 8345 2623  
E-mail: [foi@thewomens.org.au](mailto:foi@thewomens.org.au)



THE ROYAL WOMEN'S HOSPITAL - MELBOURNE

FREEDOM OF INFORMATION REQUESTS 1/7/2018 – 30/6/2019

APPLICANT'S DETAILS:

Title: ..... Surname:..... Given Name:.....

Address: .....

Suburb/Town: ..... State/Territory: ..... Postcode: .....

Telephone: ..... (Email) .....

Relationship to patient:

Self

If you are requesting your own information do you authorise us to update your address details onto the patient information system?  Yes  No

Other, please specify (eg. parent).....

If you are requesting someone else's information, please complete the authorised consent form and provide a certified photocopy of personal photographic identification of the consenting person.

Are you on a pension/health care card:  Yes  No

(If YES, please provide a certified photocopy of your pension/health care card. Application fee will be waived)

Is this request in relation to an adoption  Yes  No

Please note: Based on the decision of Justice Galvin, Administrative Appeals Tribunal of Victoria in November 1988, adoption records are exempt under sections 31, 33, 35 and 38 of the Freedom of Information Act.

PATIENT DETAILS:

First Name(s): ..... Surname: .....

Address: .....

Suburb/Town: ..... State/Territory: ..... Postcode: .....

Date of Birth: ..... Hospital Record Number:.....

INFORMATION REQUESTED FROM YOUR MEDICAL RECORD: (please specify)

1.  (tick) A complete copy of my Medical record.  (tick) A complete copy of my Baby's record.

2. All notes in my medical record relating to the following date(s) of attendance only

3. Certain sections of your medical record only

Admission Notes (please include dates) .....

Correspondence and Investigation results

Outpatient Appointment Notes

Social work notes

4. Other.....

NOTE: Please include a certified photocopy of personal photographic identification (i.e. Driver's Licence or Passport). If you have had a change in Surname due to marriage etc. please provide a certified copy of evidence, such as a marriage certificate or extract.

APPLICANT'S SIGNATURE: ..... DATE:.....



THE ROYAL WOMEN'S HOSPITAL - MELBOURNE

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AUTHORISED CONSENT TO RELEASE MEDICAL RECORDS
(To be completed only when requesting someone else's information)

Dear Freedom of Information Officer

I, ..... of (address)

.....

.....(Ph:) .....

hereby authorise and request you to supply to.....of (address)

.....

pursuant to the provisions of the Freedom of Information Act 1982, all or certain (\*) documents in your possession relating to my treatment at the Royal Women's Hospital including (where relevant);

- 1. all outpatient, casualty and inpatient records and computer data;
2. all diagnostic, progress, clinical, surgical, drug order and nursing notes and charts;
3. all referral information and letters, investigatory, investigative and diagnostic reports from all departments included in my care, including (where relevant) radiology, pathology, haematology and microbiology;
4. all records, notes, letters, reports and documents of any description produced or created by all doctors, nurses and other health care workers involved in my treatment and care and;
5. all administration charts, delivery and perinatal summaries, post mortem reports and discharge summaries and/or discharge letters.

PLEASE NOTE: SIGNED CONSENT FORM AND A CERTIFIED PHOTOCOPY OF PERSONAL PHOTOGRAPHIC IDENTIFICATION (i.e. DRIVER'S LICENCE, PASSPORT OR KEYPASS) IS REQUIRED PRIOR TO RELEASING ANY INFORMATION.

Signature: .....

Date of Birth: .....

Dated: .....

\*Please indicate the certain documents which can be released .....

.....

Health Records and Information – FOI charge

For Payment by Credit Card:

Form with checkboxes for Visa, MasterCard, and Bankcard

Please charge my credit card - Amount: \$28.90

Card Number: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Expiry Date: \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Signature: \_\_\_\_\_