

## Request for Access to Information

Dear Applicant,

Thank you for your enquiry regarding accessing information through the *Health Records Act 2001*. Please complete the enclosed application form and post it together with a photocopy of personal identification such as a Driver's Licence, Passport or Keypass to this address:

Julia Crowther  
Privacy Officer  
The Avenue Hospital  
40 The Avenue  
WINDSOR VIC 3181

Alternatively, you can scan and email the completed form to [releaseofinformation.TAH@ramsayhealth.com.au](mailto:releaseofinformation.TAH@ramsayhealth.com.au)

There are costs involved in providing information. These charges are:

- Standard application fee \$36.10
- Registered post \$12.00
- Photocopying 20c per page
- Retrieval from secondary storage \$17.30 (If applicable)  
(An invoice will follow once initial request is made)

When your application form has been received, a search will be made for the information you seek. Under the *Health Records Act 2001* and *Privacy Act 2014* an organisation has 45 days to provide the information that is being requested.

If you have any queries, please do not hesitate to call me on the number listed below.

Yours sincerely,



Julia Crowther  
Chief Health Information Manager | Privacy Officer | DVA Liaison Officer  
T: (03) 9526 5441 | E: [CrowtherJ@ramsayhealth.com.au](mailto:CrowtherJ@ramsayhealth.com.au)

## REQUEST FOR ACCESS TO INFORMATION

1. Name of Patient: \_\_\_\_\_

2. Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Name of Applicant: \_\_\_\_\_

4. What is your relationship to the patient of the requested information?

- |   |   |
|---|---|
| <input type="checkbox"/> I was the patient & I am the applicant | <input type="checkbox"/> Relative (>18 years & member of subject's household)     |
| <input type="checkbox"/> Parent                                 | <input type="checkbox"/> Exercising enduring power of attorney                    |
| <input type="checkbox"/> Spouse or De Facto                     | <input type="checkbox"/> Nominated by the subject to be contacted in an emergency |
| <input type="checkbox"/> Guardian                               |   |
| <input type="checkbox"/> Child or sibling (>18 years of age)    | <input type="checkbox"/> Intimate personal relationship with subject              |

5. Applicant's contact details:

Address: \_\_\_\_\_

\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (M) \_\_\_\_\_

Email: \_\_\_\_\_

6. Please tick or outline the specific nature of information requested:

- ☐ The entire medical record including all admissions, correspondence, investigation results and all other clinical notes.
- ☐ Certain sections of your medical record (*please detail sections in 'Other' below*)
- ☐ Progress Note/s
- ☐ Correspondence and Investigation results
- ☐ Operation Report/s
- ☐ Implanted devices/prosthesis
- ☐ Other, (please specify): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. Date Range of Information Required: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

or

☐ All admissions (*tick box*)

8. Reason for application to access documents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Do you wish to receive a copy of the information or do you wish to review the information at The Avenue Hospital?:

- ☐ Please provide me with a copy
- ☐ I wish to view the medical records

10. If a copy of the requested information is requested, please nominate a recipient:

Name of recipient: \_\_\_\_\_

Address of recipient: \_\_\_\_\_

\_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Email: \_\_\_\_\_

11. Please specify the preferred method of receiving a copy of the requested information:

- ☐ Mail ①
- ☐ Collection by the applicant ②
- ☐ Collection by the recipient nominated in Q5 above ②
- ☐ Secure Email ③. If yes, please provide an email address in Q10

① Please note that it is hospital practice to send the copy of the requested information by registered mail

② Please note that if the copy of the requested information is to be collected in person, we will require photographic identification (licence/passport) to validate the identity of the recipient

③ If you choose to have your requested information securely emailed, the Registered Postage charge of \$12 will be waived.

**I acknowledge that there may be an administrative charge involved in processing my request and providing access to the requested information. I will be provided with an estimate of the administrative charge which is to paid in full prior to gaining access to the requested information.**

**I also acknowledge that my request may be denied in accordance with the *Health Records Act (2001)* and *Privacy Act (2014)* in the instance any of the information withheld in the medical record is deemed detrimental to the applicant's or patient's physical or mental health.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_