Bethesda
health care

Application for Access to Information

RETURN TO: Health Information Manager
PO Box 45
CLAREMONT
WESTERN AUSTRALIA 6910 Ph: 9340 6300

Applicant Details:

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

Date of Birth: ..... **Telephone No(s): [H]** ..... **[Mob:]** .....

Australian Postal Address: .....

..... **State:** ..... **Postcode:** .....

Email: ..... **Date:** ..... / ..... / .....

Applicant's relationship to Patient: Self/ next of kin/ other .....

Patient Details:

Surname: ..... Given Names: ..... Date of Birth: .....

Details of Request

Describe clearly the documents you wish to access (including date, location, subject matter or any other information which would help identify the documents/information requested)

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Reason for Request

Please outline the reason you wish to access the documents/ information

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PTO

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Distribution

Requested information to be **COLLECTED** in person
(certified identification will be required prior to release of information)

OR

Requested information to be **POSTED** by registered mail
(certified identification will be required prior to release of information)

OR

Other

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(Please specify)

Fees and Charges

I acknowledge that I may be charged a fee of $95 (including GST) for the processing of my application.
This fee retrieval of information, photocopying, postage.

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APPLICANTS SIGNATURE

This application may take up to 30 days to process.

(Hospital use only)

MRN:..... Received on: ..... Acknowledgement sent on: ...../...../.....

Approval for release: ☐ YES Information dispatched Date: ...../...../.....

☐ NO Reasons for Denial / Partial Denial:

.....

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Requestor notified of Denial: ☐ YES Date: ...../...../.....

Name of Officer:..... Position: ..... Signature: .....