



APPLICATION FOR ACCESS TO INFORMATION

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

DISTRIBUTION (PLEASE CIRCLE A DELIVERY METHOD)

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 \$155.00 (including GST) for the processing of my application which includes retrieval of information, photocopying and postage.

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APPLICANTS SIGNATURE

This application may take up to 30 days to process as per legislation.

(Hospital use only)

MRN: Received on: / / Acknowledgment 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: