

## **APPLICATION FOR ACCESS TO INFORMATION**

RETURN TO: Health Information Manger PO Box 45 CLAREMONT **WESTERN AUSTRALIA 6910** 

Ph: 9340 6300

APPLICANT DETAILS		
May / Mayor / Maior / May / Dwg		Civan Namas
		Given Names:[M]
		10-11
		Postcode:
Email:		
Applicants relationship to Patient: Self	/ Next of kin / Other	 
	5 4001/5	
PATIENT DETAILS  TICK IF SAME A	72 AROVE	
Surname:	Given Names:	 Date of Birth:
DETAILS OF REQUEST		
identify the documents/information req	juested)	tter or any other information which would help
REASON FOR REQUEST		
		 PTO



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DISTRIBUTION (PLEASE CIRCLE A DELIVERY METHOD)				
	Requested information to be <b>COLLECTED</b> in person (Certified identification will be required prior to release of information)			
	OR			
	Requested information to be <b>POSTED</b> by registered mail			
	(Certified identification will be required prior to release of information)			
	OR			
	Other			
	(Please specify)			
FEES AND C	HARGES			
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.				
	APPLICANTS SIGNATURE			
This application may take up to 30 days to process as per legislation.				
	(Hospital use only)			
MRN:				
Approval for				
Approvarior	No Reasons for Denial / Partial Denial:			
Requestor n	otified of Denial: Yes Date:/			
Name of Off	_			