



APPLICATION FOR ACCESS TO INFORMATION

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

DISTRIBUTION (Tick a Delivery Method)

- Collect** *in person by appointment (proof of ID is required for collection)*
- Post** *by registered mail (must be Australian address)*
- Email** - *Secure attachment*

If selected, please provide email or postal address details of where copy is to be sent

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APPLICANT DECLARATION (Please Tick)

- I am requesting my own record, or I have attached a copy of patient consent.*
 - *If you are requesting information about somebody else, a certified copy of signed and dated patient consent must be attached to this application*
 - *If the patient is deceased, certified consent from the executor(s) or administrator(s) of the estate must be provided and signed by all nominated representatives, along with certified proof of their appointment.*
- I have included a certified copy of signed photo identification. (e.g. Driver's license, or passport)*
 - *Certified photo identification has been provided for both the patient and applicant, if they are different*

FEES AND CHARGES (Please Tick)

- I acknowledge that I may be charged an administration fee for the processing of my application which includes retrieval of information, photocopying, postage and delivery. An invoice will be provided which is to be paid prior to the requested information being released.*

Applicants Signature: Date:/...../.....

Electronic signatures are not accepted, handwritten signatures only

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: