



## Freedom of Information Request Form

### Patient Details

Name: \_\_\_\_\_

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

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

Phone contact no: \_\_\_\_\_ or \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

UR Number (if known): \_\_\_\_\_

### PLEASE PROVIDE PHOTO ID

#### Documents Required (please tick box below)

I would like access to my medical record under the Freedom of Information Act 1982 *Victoria*.

Complete copy      or       Part (please specify what information is required)

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

Signed: ..... Date: .....

### Complete this section if seeking information other than your own.

**Patient must sign area below if asking family member to act on their behalf.**

#### Where the patient is deceased:

The patient's Executor of the Will must sign the authorisation and a copy of the Will for proof must be provided.

Where there is no Will the senior next of kin must sign the authorisation and supply proof of relationship and photo ID must accompany the request.

NAME: ..... RELATIONSHIP: .....

ADDRESS: .....

..... POSTCODE: .....

CONTACT NO: .....

**PATIENT Sig:** ..... **Date** .....

**EXECUTOR Sig:** ..... **Date** .....