



**Sir Charles Gairdner Hospital
Freedom of Information Application Form**



**SEND TO: FOI COORDINATOR, MEDICAL RECORD DEPARTMENT, SIR CHARLES GAIRDNER
HOSPITAL, HOSPITAL AVENUE, NEDLANDS WA 6009**
Fax: 08 9346 4473

Details of Applicant

Surname: _____ Given Name: _____

Postal Address: _____

Postcode: _____ Telephone (H): _____ (W): _____

Date of Birth: _____ Hospital Unit Number (if known): _____

Details of Patient (if requesting on their behalf)

Surname: _____ Given Name: _____

Date of Birth: _____ Hospital Unit Number (if known): _____

Are you this person's closest living relative? Yes No

Request Details (Please ✓)

Medical Record Other → Please state: _____

Describe clearly the documents you require: _____

Type of Access (Please ✓)

I wish to inspect the document(s): Yes No

I require a copy of the document(s): Yes No

Fees, Charges & Signature

There are no fees or charges for inspecting or receiving a copy of your medical record. Non personal information is subject to an application fee of \$30 00.

Applicant's Signature: _____ Date: _____

What to send with the application form

- Please attach cheque to application form if applicable.
- **If you are requesting access to your medical record you will need to include proof of identity. A photocopy of one of the following is acceptable: Driver's Licence, Passport, Birth Certificate or other appropriate documentation.**
- If you require access to the medical record of another person, **you will need to provide an original written consent signed by that person.**
- If the information requested relates to a deceased person, access will be granted to the person's closest relative who is 18 years or over. Proof of this relationship is required.