



MR/CR980

FREEDOM OF INFORMATION RECORD ACCESS

Surname:.....

Given Names:.....

Date of Birth:..... Gender:.....

UR No.:.....

(AFFIX PATIENT LABEL HERE)

Please Return Form to: The Freedom of Information Officer
South Gippsland Hospital
87 Station Road
FOSTER VIC 3960

Applicant/Patient/Clients Details: (Please print details of the patient/client whose file is being requested)

Mr / Mrs / Ms / Other _____ Surname: _____

Given Name: _____

Did patient/client attend SGH under another name? If so, please specify: _____

Date of Birth: ____ / ____ / ____

Postal Address: _____

_____ Post Code _____

Phone Number (H) _____ (W) _____ (M) _____

E-mail address: _____

If you are not the patient/client to whom the request relates please supply us with your contact details:

Surname: _____ Given name: _____

Address: _____ Postcode: _____

Phone Number (H) _____ (W) _____ (M) _____

E-mail address: _____

What is your relationship to the Patient/Client? (Please tick)

Relative Friend Legal Guardian Carer Other

Are you the patient/client's Next of Kin Yes No Don't know

Have you got the patient/client's authority Yes (please attach) No

Signature:..... Date:.....

Name/Designation:..... Time:.....



MR/CR980 - v5
08_2025

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Type of Access (please tick)

- I want to inspect the document/s
- I want a copy of the document/s
- I want a medical record summary
- I want an interpretation of the record
- I want access in another form (please specify) _____

Request: (please tick)

I wish to access: All of the record Part of the record

If part of the record is required only, please specify the part (s) of the document you require:

List of Current Fees and charges (for the Financial Year 2025/26)

Application Fee:	\$33.62 (NON-REFUNDABLE) <small>If paying the application fee will cause you financial hardship, please provide a copy of your concession or healthcare card so that we may assess eligibility for a fee waiver</small>
Search Charge:	\$20.00 per hour of part thereof
Supervision Charge:	\$5.00 per quarter hour or part thereof
Photocopy Charges:	\$0.20 per photocopied page
Postage Charges:	\$10.00 when sent via registered mail

Proof of Identification: Please include details of proof of identity. Photocopy to be included.

- Driver's Licence, Passport, Medicare Card. (Please specify number) _____
- Viewed Copies certified

I understand that the charges may be made under the Freedom of Information Act (1982) in respect of this request and that I will be supplied with a statement of charges, if appropriate. I also understand that I will have to supply a certified proof of identification.

Signature:..... Date:.....

Name/Designation:..... Time:.....

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