Freedom of Information Request Form

PORTLAND DISTRICT HEALTH

Patient/Client Details					
Family Name:		Given & Middle Names:			
Previous Name:			Date of Birth:	/ /	
Residential Address:				Post Code:	
Postal Address: (Leave Blank if same as above)				Post Code:	
Write in Preferred Contact Box					
Home Number		Mobile Number		Business Number	

I would like access to the following documents from the dates / / to / /

☐ Discharge Summary	☐ Emergency Presentation	☐ Other
☐ Operation Report	☐ X -Rays Result	(specify)
☐ Admission	☐ Blood test Results	

Tick whether you would like to inspect the documents and/or obtain a copy of the documents	Inspection ☐	Copy ☐

I understand that no information will be released until PDH has received the **$26.50** FOI application fee along with any service charges that may be made in respect of this request. Proof of identification is required prior to release of the information. Please enclose a photocopy of photo ID (e.g. drivers licence) or birth certificate or present proof of identity when inspecting or picking up the information.

Signature..... Date.....

Relationship to Patient ……

Return to Freedom of Information Officer, Portland District Health, Bentinck Street, Portland 3305 with application fee and proof of ID if required enclosed.

Office use only –Identification Sighted – TYPE DATE / / STAFF