

**SOUTH WEST HEALTHCARE  
FREEDOM OF INFORMATION ACCESS REQUEST FORM**

Please complete the following details and return form with:-

- ✧ Two Forms of Proof of Identification (e.g. photocopy of Driver's Licence or passport, Medicare Card)
- ✧ Application Fee - \$31.80 If you are unable to pay the fee on a basis of hardship, please provide evidence which supports your claim (eg. Copy of a current Health Care Card).

ATTENTION TO: Freedom of Information Officer - South West Healthcare - Ryot Street, Warrnambool, 3280  
✧ PH: 5563 1578 ✧ Fax: 5563 1463 ✧ Email: [foi@swh.net.au](mailto:foi@swh.net.au)

**APPLICANT DETAILS**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Previous Name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_ Suburb: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Postcode: \_\_\_\_\_ State: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Email Address: \_\_\_\_\_

**PATIENT DETAILS (If different from above)**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Previous Name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_ Suburb: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Postcode: \_\_\_\_\_ State: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**I wish to obtain the following documents (please tick appropriate box):**

- General Medical Record (includes Inpatient, Emergency Department and Outpatient records)**  
Please specify dates/details: \_\_\_\_\_
- Mental Health Record (includes Inpatient and Outpatient records)**  
Please specify dates/details: \_\_\_\_\_
- Centre Against Sexual Assault (CASA)**  
Please specify dates/details: \_\_\_\_\_
- Dental Clinic**  
Please specify dates/details: \_\_\_\_\_
- South West Medical Centre (GP Clinic)**  
Please specify dates/details: \_\_\_\_\_

Reason for request: \_\_\_\_\_

I accept responsibility for payment of the application fee of \$31.80 plus an additional charge of 20 cents per copy obtained, plus postage. I understand that an additional charge may be levied if considerable time is involved in processing my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_