

Freedom of Information - Access Request Form

Please return form with application fee to: Health Information Manager
Dental Health Services Victoria
720 Swanston Street, Carlton VIC 3053

1. Patient Details

Surname: Given Name(s): Date of Birth:/...../..... UR Number (if known):

2. Applicant Details (Person making request)

Surname: Given Name(s): Title: (Mr/Mrs/Ms/Miss/Other): Date of Birth:/...../..... Postal Address: Postcode: State: Previous Address: (If relevant for identifying records) Postcode: State: Telephone Number(s): Home () Work/Mobile () Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Carer <input type="checkbox"/> Other _____

3. Details of Request (Please Tick)

- I want access to x-rays only
- I want access to medical notes only
- I want access to photographs only
- I want access to the entire dental record (including x-rays, medical notes, correspondence & photographs)

4. Form of Access (Please Tick **one** box only)

- I want to inspect the relevant information
- I want a copy or print out of relevant information

I understand that a non-refundable fee must be paid and in addition other fees may be charged in respect to this request and that I will be supplied with notification of these fees if appropriate prior to the receipt of any documents.

Signature: **Date:**/...../.....