





**APPLICATION FOR ACCESS TO INFORMATION**

RETURN TO: Health Information Manger  
PO Box 45  
CLAREMONT  
WESTERN AUSTRALIA 6910  
Ph: 9340 6300

**DISTRIBUTION (PLEASE CIRCLE A DELIVERY METHOD)**

Requested information to be **COLLECTED** in person  
(Certified identification will be required prior to release of information)

**OR**

Requested information to be **POSTED** by registered mail  
(Certified identification will be required prior to release of information)

**OR**

Other

.....  
.....  
.....

*(Please specify)*

*\* Proof of Identification is required to collect requested information in person*

**FEES AND CHARGES**

I acknowledge that I may be charged an administration fee for the processing of my application which includes retrieval of information, photocopying, postage and delivery. An invoice will be provided which is to be paid prior to the requested information being released.

Applicants Signature: ..... Date: ...../...../.....

**This application may take up to 30 days to process as per legislation.**

*A certified original copy of identification (e.g. photocopy of passport or drivers' licence) must accompany the application form, for the application to be processed.*

*(Hospital use only)*

MRN: ..... Received on: ...../...../..... Acknowledgment sent on: ...../...../.....

Approval for release:  Yes Information dispatched Date: ...../...../.....  
 No Reasons for Denial / Partial Denial: .....

Requestor notified of Denial:  Yes Date: ...../...../.....  
Name of Officer: ..... Position: ..... Signature: .....