Appendix 9.3

ARMADALE MENTAL HEALTH SERVICE

REQUEST TO ACCESS DOCUMENTS (Mental Health Act 2014)

Consumer's Surname Name: _____ Consumer's Given Names: _____

Postal Address: _____ Postcode:_____

Phone: Hm: _____Wk: _____ Mb: _____ Date of Birth: ___/___/____

Applicant Details: As Above ☐ Nominated Person ☐

Surname Name: _____ Applicant's Given Names: _____

Postal Address: _____Postcode: _____

Phone: Hm: _____Wk: _____ Mb: _____ Date of Birth: ___/___/____

Relationship to patient: Spouse Parent Guardian Son/Daughter Other (Please specify): _____ Proof of guardianship:

DETAILS OF REQUEST:

I am applying for access to document(s) pertaining to: (*include relevant date/s of contact with service and treatment details*)

FORM OF ACCESS: *(Please tick one)*

I wish to inspect the document(s)

I require a copy of the document(s)

I require access in another form

I would prefer to have the documentation: *(Please tick one)*

Posted to above address:

Personally collected on ___/___/____

My record to be collected by _____

I authorise the person nominated above to collect my medical records on my behalf:

APPLICANT'S SIGNATURE: _____ **DATE:** ___/___/___

Please send to: Freedom of Information Coordinator, Patient Information Service, Armadale Health Service, PO BOX 460 Armadale WA 6992

(Office Use Only)
UMRN: _____ Psychiatrist (If active): _____
Application received on: ___/___/___ Acknowledgement sent: ___/___/___
Deadline for response: ___/___/___
Proof of Identity (If required): Driver's License Passport: Medicare: Birth Certificate
Signed: _____ Print:_____ Designation:_____ Date:___/___/___