

# VICTORIA Application to Amend Health Records



## APPLICANT DETAILS

Mr/Mrs/Ms/Dr ..... Surname ..... Given names .....  
(include previous name if applicable)

Date of Birth ...../...../..... Phone (H) ..... (W) ..... (M) .....

Address ..... State ..... Postcode .....

**Are you applying on behalf of another person?** (Circle your response) Yes No  
**If yes, please provide details of the other person:**

Mr/Mrs/Ms/Dr ..... Surname ..... Given names .....  
(include previous name if applicable)

Date of Birth ...../...../..... Your relationship to this person .....

*If you are applying on behalf of someone else, you must provide identification (eg, birth/marriage/death certificate/s) clearly showing you are the closest relative to the subject of the application, in addition to personal identification. If you are not the closest relative, you must provide written authorisation from the closest relative permitting you to access the information. Authorisation forms are available by contacting us (see contact numbers overleaf).*

## DETAILS OF INFORMATION TO BE AMENDED

Please give details of the information you wish to be amended - include title, date and author of the document/s if possible.

.....  
.....

## REASON FOR AMENDMENT

This information is (circle response): **Inaccurate Incomplete Out of Date Misleading**

Please describe why you believe the information is inaccurate/incomplete/out of date/misleading.

.....  
.....

## FORM OF AMENDMENT

Type of amendment requested (circle response): **Alteration Insertion Insert a file note**

Please describe the changes you require. You may attach additional information to this form.

.....  
.....

I have attached a photocopy of my passport or driver's licence. **Yes**

**Applicant's Signature** ..... **Date** .....

## Hospital/Service use only

MRN ..... Received on ...../...../..... at .....

Proof of Identity Type ..... Photocopy attached/sighted .....

Acknowledgement sent on ...../...../.....

Name of officer ..... Signature .....

## VICTORIA CONTACT DETAILS

Please mail or fax your completed application form to the relevant St John of God Health Care hospital or service. The contact details for our hospitals in Victoria are listed below.

Please feel free to contact the relevant hospital by telephone if you have any questions regarding this form.

### OUR HOSPITALS

#### St John of God Ballarat Hospital

Health Information Manager  
PO Box 20  
Ballarat VIC 3353  
Tel: 03 5320 2111  
Fax: 03 5333 1682

#### St John of God Bendigo Hospital

Health Information Manager  
PO Box 478  
Bendigo VIC 3552  
Tel: 03 5434 3206  
Fax: 03 5434 3248

#### St John of God Berwick Hospital

Health Information Manager  
PO Box 101  
Berwick VIC 3806  
Tel: 03 9707 1900  
Fax: 03 9707 4135

#### St John of God Geelong Hospital

Health Information Manager  
PO Box 1016  
Geelong VIC 3220  
Tel: 03 5226 8888  
Fax: 03 5221 8807

#### St John of God Frankston Rehabilitation Hospital

Health Information Manager  
255-265 Cranbourne Road  
Frankston VIC 3199  
Tel: 03 9788 3333  
Fax: 03 8790 8747

#### St John of God Pinelodge Clinic

Health Information Manager  
1480 Heatherton Road  
Dandenong VIC 3175  
Tel: 03 8793 9444  
Fax: 03 5564 0699

#### St John of God Warrnambool Hospital

Health Information Manager  
PO Box 316  
Warrnambool VIC 3280  
Tel: 03 5564 0600  
Fax: 03 5564 0699

### OUR PATHOLOGY SERVICE

#### St John of God Pathology

Operations Manager  
235 Ryrie Street  
Geelong VIC 3220  
Tel: 1800 676 823  
Fax: 03 5222 5691