

Coastwide Eye Surgery
REQUEST FOR ACCESS TO RECORDS
Freedom of Information Acts, 1997 & 2003

1. DETAILS OF REQUESTER (Please use block capitals)

Surname _____
First Name _____
Postal Address _____

Tel Home: _____ Tel. Business _____
Fax No: _____ Email Address: _____

2. PERSONAL INFORMATION

Before you are given access to personal information relating to yourself, you may be required to produce a Birth Certificate, Driving Licence, Passport or other form of identity. **A copy of the identifying document accompanies this form: Yes [] No []**

3. FORM OF ACCESS

My preferred form of access is: *(please tick as appropriate)*
To receive photocopies: *(photocopying charges will apply)* []
To inspect original record: []
Other format *(Please specify)*: _____

4. DETAILS OF REQUEST

In accordance with Section 7 of the Freedom of Information Act 1997 & 2003, I request access to records of _____ . In the space below please describe the records you seek as fully as you can as this will assist in dealing with your request. If you require more space to complete your description, please attach a page.
I request the following records: _____

PLEASE SIGN HERE _____ **DATE** _____

Please send your completed application to: **Practice Manager**
Gt lpc "Uwlg'3-29'Rr vlpwo 'Dwlf lpi 'b'Kf c'Cxgpgw'GTfP C'44722 Tel: (02) 4365-9444 Fax: (02) 4367-6593
Y { qpi "Uwlg'4'Tqdnf{ 'J qwug'46/48'J gr 'Utggy'Y [QPI '447; Tel: (02) 4355-5600 Fax: (02) 4353-7799