

**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.

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This information is (circle response): **Inaccurate Incomplete Out of Date Misleading**

Please describe why you believe the information is inaccurate/incomplete/out of date/misleading.

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**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.

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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 .....

**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 and services in Victoria are listed below.**

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

## **OUR HOSPITALS**

### **St John of God Hospital Ballarat**

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

### **St John of God Hospital Bendigo**

Health Information Manager  
PO Box 478  
Bendigo VIC 3552  
Tel: 03 5434 3434  
Fax: 03 5434 3455

### **St John of God Hospital Berwick**

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

### **St John of God Hospital Geelong**

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

### **St John of God Nepean 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 Hospital Warrnambool**

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

## **OUR SERVICES**

### **Pomegranate House**

Health Information Manager  
103 Webster Street  
Ballarat VIC 3350  
Tel: 03 5320 2260  
Fax: 03 5331 8455

### **Raphael Centre Berwick**

Health Information Manager  
57 Fairholme Boulevard  
Berwick VIC 3806  
Tel: 03 9707 3988  
Fax: 03 9707 0297

### **Raphael Centre Geelong**

Health Information Manager  
11 Fenwick Street  
Geelong VIC 3220  
Tel: 03 5221 7333  
Fax: 03 5221 9766

### **Raphael Centre South West Victoria**

Health Information Manager  
PO Box 316  
Warrnambool VIC 3280  
Tel: 03 5564 0636  
Fax: 03 5564 0699