MR1046

the women's
the royal women's hospital

Release of Information Request

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: ____

(AFFIX PATIENT LABEL)

Please forward this form to:
Medical Enquiries Desk
Health Information Services
Email: Medical.Enquiries@thewomens.org.au Phone: 8345 2616 Fax: 8345 2623

DETAILS OF PATIENT

Surname: _____ Given names: _____

Name when last attended hospital: *(If different to current name)* _____

Address: *(Past address if applicable):* _____

_____ Postcode: _____

Telephone: _____ Date of Birth: ____/____/____

INFORMATION TO BE RELEASED TO *(Note: Information can only be released to a medical provider)*

Name: _____

Hospital / Organisation: _____

Postal address: _____

Telephone / Pager: _____ Fax: _____

How and when information is to be released: ☐ Phone ☐ Fax ☐ Mail Date required: ____/____/____

INFORMATION REQUIRED *Specify information required (e.g. specific diagnosis, tests)*

☐ Discharge Summary: _____

☐ Outpatient / Correspondence: _____

☐ Investigation Results: _____

☐ Other, please specify: _____

PATIENT CONSENT TO RELEASE INFORMATION

Provided: *(Please tick)* ☐ **Below** **OR** ☐ **Separate**

(Request will not be processed without written consent of the patient, parent, guardian or person responsible for patient OR clinician complete and sign the clinician certification below).

I, _____ authorise the release of my (or my child's) relevant health information as specified above. I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below.

Signature: _____ Print name: _____ Date: ____/____/____

(Patient, Parent, Guardian or Person responsible for Patient)

CLINICIAN CERTIFICATION IN LIEU OF PATIENT CONSENT

I confirm that the information requested above is needed for the patient's current treatment, and in the interests of the patient's ongoing health care. The patient's next appointment is on ____/____/____
(Date)

Signature: _____ Print name: _____ Date: ____/____/____

(Requesting Clinician or Health Provider Representative)

FOR INTERNAL USE ONLY

UR number: _____ Request received by: _____ Date: ____/____/____

Consent: ☐ Yes ☐ No Request processed by: _____ Date: ____/____/____

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RWH
Oct 2018