AFFIX PATIENT IDENTIFICATION LABEL HERE

Mater Newcastle

SURNAME .... MRN ....

OTHER NAMES ....

ADDRESS ....

DATE OF BIRTH .... AMO ....

REQUEST AND AUTHORITY FOR RELEASE OF INFORMATION

I hereby request the Health Information Service to release the following information:

Patient Details:

Surname: .... Other Names: ....

Previous or Alias Names: .... Date of Birth: .... / .... / ....

Current Address: ....

.... Postcode: ……………..……..

Telephone Contact: Home .... Work .... Mobile ....

Please Send To:

Name of Doctor/Recipient: ....

Postal Address: ....

.... Postcode: ....

Telephone Number: .... Fax Number: ....

Relationship to Patient: ………………………………...

Reason For Request: ....

Information Requested:

Treatment Date(s) : ....

Information Requested (please specify): ....

....

Signature of Requestor: .... Date ....

Print Name: .... Telephone Number: ....

If not patient, relationship to patient: ....

This authority remains valid for 12 months from the above date

ROI Office Use Only: DETAILS ARE TO BE ENTERED INTO THE ROI D/B INITIALLY & UPDATED AS ACTIONS OCCUR

No Patient Authority Required :

☐ Current GP Listed in Medical Record / iPM / Front Sheet

☐ CMN or HNE Health **treating** health professional / Referring M.O.

☐ Guardianship - Evidence required to be filed in medical record

☐ Enduring Guardian - Evidence required to be filed in medical record

☐ Coroner, Subpoena, Police Warrant, Chapter 16A Child Protection

Fee Details:

☐ No Fee Required - State reason ....

☐ Fee Applies: Amount $……… Date Requested: ….. /…. / …..

☐ Fee Received: Amount $.......... Date Received: ….. /…. / …..

Authority Required :

☐ Patient requires information to be sent to non-treating health professional / GP **not** listed as 'current' for CMN

☐ Private Hospitals ☐ Non HNELHD Hospitals

☐ Next of Kin ☐ Carer ☐ Other Health Professional

☐ Solicitor ☐ Insurer ☐ Police must go through ROI or DMS

☐ MHS/Other Patient Safety Officer refer to DMS

☐ Other Specify: ………………………………………………

☐ *Authority Received / Checked*

Date: ………/…….. /……… Signed: ……………………………

Information sent as requested: ☐ Yes ☐ No

Method of Delivery: …………………………………………………………………........

Anything Withheld describe: ....

If no, reason: ………... ☐ Entered in ROI Database

Request processed by: ……………………………..……………… ………...……………………………………… Date: ….. /…. / …..

Printed Name Signature

Issued: Aug 98; Revised: Mar 99; Nov 02; Jun 05; Dec 05, Jul 07, Jul 11, Mar 16, Mar 22 Questions Phone 0240144829 or 02 40144820

Original request is to be filed in the patient's Hospital medical record