



**MILDURA  
BASE PUBLIC  
HOSPITAL**

**RELEASE OF INFORMATION  
REQUEST FORM**

AFFIX PATIENT LABEL HERE  
(IF AVAILABLE)

**PATIENT DETAILS**

SURNAME	
GIVEN NAMES	
DATE OF BIRTH	
ADDRESS	
SUBURB / TOWN / CITY	
POSTCODE	
PHONE	

**INFORMATION TO BE RELEASED TO:**

NAME		
RELATIONSHIP TO PATIENT	<input type="checkbox"/> Treating Doctor	<input type="checkbox"/> Other (Please specify)
HOSPITAL / ORGANISATION		
POSTAL ADDRESS		
EMAIL ADDRESS		
PHONE NUMBER		
FAX NUMBER		
HOW & WHEN INFORMATION IS TO BE RELEASED	<input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email	<input type="checkbox"/> Urgent (within 48 hours) <input type="checkbox"/> Non Urgent - Date Required: ____/____/____

**INFORMATION REQUIRED**

DATES		
<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> INVESTIGATION RESULTS	<input type="checkbox"/> CLINICAL NOTES
OTHER (Please specify)		

**PATIENT CONSENT TO RELEASE OF INFORMATION**

I,..... authorise the release of my (or my child's) relevant health information as specified above.  
I understand I may revoke this consent at anytime 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: \_\_\_\_\_  
(Patient, Parent, Guardian or Personal Responsible for Patient)

Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE FORWARD THIS FORM TO THE  
RELEVANT HOSPITAL FOR PROCESSING**

**HEALTH INFORMATION SERVICES**  
PO BOX 620  
MILDURA VICTORIA 3502  
PH: 03 5022 3305 FAX: 03 5022 3306  
EMAIL: [HIS@mbph.org.au](mailto:HIS@mbph.org.au)