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	☐ Treating Doctor	☐ Other (Please specify)
HOSPITAL / ORGANISATION		
POSTAL ADDRESS		
EMAIL ADDRESS		
PHONE NUMBER		
FAX NUMBER		
HOW & WHEN INFORMATION IS TO BE RELEASED	☐ Fax ☐ Mail ☐ Secure Email	☐ Urgent (within 48 hours) ☐ Non Urgent - Date Required: ____ / ____ / _____

INFORMATION REQUIRED

DATES		
☐ DISCHARGE SUMMARY	☐ INVESTIGATION RESULTS	☐ 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: HISinfo@mbph.org.au