



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 Records and Information Services**

Email: [Medical.Enquiries@thewomens.org.au](mailto: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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

RELEASE OF INFORMATION REQUEST

MR/1046