AUTHORITY FOR RELEASE OF DETAILS FROM A PATIENT'S MEDICAL FILE

Under the Privacy Act this hospital can only release details about a patient with the express written consent of the patient or their legal guardian.

Consent must be original and dated. Photocopies and faxes are not accepted.

If the patient is agreeable that the Applicant should be provided with information from their medical file, please complete the authority below and return it to this office so that the request may be processed.

Applicant : e.g.GP/Specialist/ Optometrist/Solicitor/Insurance/Police

Request Details:

…….. ……

…….. ……..

…… ……

Medical file

Name of Patient: …….

Date of Birth: …….

Authority

I hereby authorise the Eye & Ear Hospital to release details from my medical record at the hospital to the Applicant named above.

Signature: ……

Print name: ……..

Date: ……

PLEASE RETURN THIS FORM TOGETHER WITH ANY WRITTEN REQUEST TO

OUTPATIENT BOOKINGS UNIT, LOCKED BAG 8, EAST MELBOURNE 8002

TELEPHONE 61 3 9929 8500 FAX 61 3 9663 7203