the royal victorian eye and ear hospital

Authority for Release of Information from a Patient's Medical Record

Insert Patient Label

UR No: ....

Surname: ....

Given Name: ....

Date of Birth: .... Sex: M or F

Address: ....

RVEEH_MR31

In accordance with the *Privacy Act 1988*, the Royal Victorian Eye & Ear Hospital can only release information 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 acceptable.

If the patient agrees that the Applicant should be provided with information from their medical record, please complete the authority below and return it to Health Information Services so that the request may be processed.

Applicant Details

- ☐ GP
- ☐ Optometrist
- ☐ Specialist
- ☐ Solicitor
- ☐ Police
- ☐ Insurance

Contact Name: ______________________________

Address: ______________________________

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Phone: ____________________

Request Details

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Patient Details

Name: ______________________________

Date of Birth: ______________________________

UR Number (if known): ______________________________

Authority

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

Signature ______________________________

Print Name ______________________________

Date ____________________

Please return this form together with any written request to:

Health Information Services, Locked Bag 8, East Melbourne, 8002

Phone: (03) 9929 8230 Fax: (03) 9929 8228

I/H 06/2019

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