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ALEAST ME TO THE TOTAL TO THE TOTAL	UR Number: Family name: Given names:			
RELEASE OF INFORMATION	Date of birth:/ MO:			
REQUEST	(Affix patient identification label here if available)			
URGENCY				
☐ URGENT ☐ Not Urgent				
REQUESTING HEALTH SERVICE DETAILS				
Requesting Clinician:	Department:			
	Phone:			
HEALTH INFORMATION REQUESTED				
Health Service:				
r attent Name.	DOB			
☐ Discharge summary				
Outpatient correspondence				
☐ Investigation results				
☐ Other (please specify)				
PATIENT CONSENT TO RELEASE INFORMATION				
☐ I, the above named patient, consent to the release of health information (including test results etc) about past and present illness to the Doctor or health care provider making this request. I understand this is necessary for my ongoing treatment.				
Patient Name:				
Signature: Date:/				
OR				
CLINICIAN CERTIFICATION IN LIEU OF PATIENT CONSENT				
☐ It is impracticable to provide patient consent at this time. I verify that I am treating this patient and that the health information requested above is required for their ongoing treatment.				
Print name: Signat	Signature: Date://			
	F			
Street Address: Northeast Health Wangaratta	Postal Address: PO Box 386			

35-47 Green St

Wangaratta VIC 3677

www.northeasthealth.org.au

Wangaratta VIC 3676

NHW endeavours to comply with the Health Records Act 2001 and other relevant legislation when handling health information. The health information requested from your service is done so with the understanding that it will be used by the requesting clinician for its primary purpose or for a directly related secondary purpose. The health information requested will be treated confidentially and in accordance with the legislative requirements of the Health Records Act 2001, Privacy and Information Act 2000.

DO NOT WRITE IN THIS BINDING MARGIN