RELEASE OF INFORMATION REQUEST

UR Number: _____

Family name: _____

Given names: _____

Date of birth: _____/_____/_____ MO: _____

(*Affix patient identification label here if available*)

URGENCY

☐ URGENT ☐ Not Urgent

REQUESTING HEALTH SERVICE DETAILS

Requesting Clinician: _____ Department: _____

Health Service: _____

Fax/Email: _____ Phone: _____

HEALTH INFORMATION REQUESTED

Health Service: _____

Patient 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: _____ Signature: _____ Date: ___/ ___/ _____

Phone: _____ Fax: _____

Street Address:
Northeast Health Wangaratta
35-47 Green St
Wangaratta VIC 3677
www.northeasthealth.org.au

Postal Address:
PO Box 386
Wangaratta VIC 3676