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

Please complete this form and fax to:
NHW Health Information Services

Fax: 03 5718 0226
Email: health.information@nhw.org.au
Phone: 03 5722 5266

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: _____

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

RELEASE OF INFORMATION REQUEST UR 06-07

VER 10/25