

The Royal Women's Hospital

RELEASE OF INFORMATION REQUEST FORM

The Royal Women's Hospital
Patient Label

Details of Patient:

Surname:	Given names:	
Name when last attended hospital: <small>(If different to current name)</small>		
Address: <small>(Past address if applicable)</small>	Postcode:	
Telephone:	Date of birth:	

Information to be released to:

Name:		
Relationship to patient:	<input type="checkbox"/> Treating Doctor <input type="checkbox"/> Other, please specify _____	
Hospital/Organisation:		
Postal address:		
Telephone/Pager:	Fax:	
How and When Information to be released: <small>Please refer to back of form for guidelines on release of information</small>	Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/>	Urgent <input type="checkbox"/> NonUrgent <input type="checkbox"/> Date Required: <u> </u> / <u> </u> / <u> </u>

Information required:

Specify information required (eg. specific diagnosis, test)

Discharge summary: <input type="checkbox"/>	
Outpt/correspondence: <input type="checkbox"/>	
Investigations Results: <input type="checkbox"/>	
Other, please specify: <input type="checkbox"/> <small>(eg. clinical summary)</small>	

Patient consent to release of information:

Provided: (please tick)

Below

or

Separate

(Request will not be processed without written consent of the patient, parent, guardian or person responsible for patient)

I, authorise the release of my (or my child's) relevant health information as specified above.

I understand I may revoke this consent at anytime except to the extent that action has already been taken on it and that it will expire automatically one (1) year from the date indicated below

Signature: _____ Print name: _____ Date: _____
(Patient, Parent, Guardian or Person Responsible for Patient)

Please forward this form to relevant hospital for processing.

Royal Women's Hospital
Health Information Services
Medical Enquiries
132 Grattan Street
Carlton 3053 Phone: 9344 2005 Fax: 9344 2062

FOR INTERNAL USE ONLY	Request received by:	Date:
UR Number:	Request processed by:	Date:
Consent: Yes <input type="checkbox"/> No <input type="checkbox"/>		

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