HIGH STREET MEDICAL CLINIC	# Consent for Release of Patient Information

Details of Practice/Hospital/Other:

Name:..

Hospital/Practice/Other:...

Phone No:..**Fax No:**...

Urgency of Request: *(please circle)* **Urgent** **Next Day** **Non-Urgent** *(within 5 business days)*

Patient Details:

Patient Name:..

Address:...

Sex: M / F **DOB:**..

Information Required: *(Please tick & specify dates if known)*

☐ **Patient Summary**..

☐ **Correspondence**..

☐ **Operation Reports**..

☐ **Investigations**..

☐ **Other**..

....

Patient Consent Details: *(please tick & sign as appropriate)*

☐ *I, the above named patient consent to the release of health information (including test results etc.) about past and present illness to the Doctor, Healthcare Provider, Solicitor, Insurance Company making this request.*

Signed:... Date: / /

(Patient, Parent or Legal Representative)

.... Date: / /

(Relationship to patient)

.... Date: / /

(Witness)

☐ It is impracticable to provide patient consent at this time. I verify that I am treating this patient and the information is required for their ongoing treatment.

Doctor Signature:.. **Date: / /**

High Street Medical Clinic endeavours to comply with *Health Records Act 2001* and other relevant legislation when handling health information. The health information enclosed is being provided to your service on the understanding that it is used for its primary purpose pr a directly related second secondary purpose. Disclosure of this health information to your service imposes on you an obligation to treat this information confidentially and in accordance with legislative requirements of the *Health Records Act 2001* and *Information Privacy Act 2000.*

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