**Authority to Release Healthcare Information**

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| --- | --- | --- | --- | --- |
| Patient name: | |  | | |
| Previous name:  Date of Birth:  Medicare Number: | |  | | |
|  | | | | |
| I accept and authorize:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (previous practice name)  to release Healthcare information of the patient named above to: | | | | |
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|  | | | | |
| Name: **Health on Central**  Address: **26 Central Drive** | | | |  |
| Suburb: **Andergrove** | State: **Qld** | | | Postcode: **4740** |
| Phone: **07 4955 0555** | | | Fax: **07 4955 0993** | |
| Email: **admin@healthoncentral.com.au** | | | | |
|  | | | | |
| This request and authorisation applies to: | | | | |
|  | | | | |
| Health Summary only  All Healthcare Information (patient is aware a fee may be charged directly to them and to contact your practice to enquire if payment is required). We are on Best Practice and accept XML or Medical Objects. | | | | |
| Healthcare information relating to the following treatment, condition or | | | | |
| Dates \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Other (please specify) | | | | |
|  | | | | |
|  | | | | |
| Patient signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | | | | |
| If not signed by a patient indicate relationship of authorising person to Patient | | | | |
| Parent or guardian of a minor | | | | |
| Guardian | | | | |
| Other (please specify): | | | | |
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| This request expires 90 days after the request is signed | | | | |
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