**Authority to Release Healthcare Information**

|  |  |
| --- | --- |
| 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: |
|  |
|  |
| 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):  |
|  |
|  |
|  |
| This request expires 90 days after the request is signed |
|  |
|  |