Authority to Release Healthcare Information

Patient full name:	
Previous name (if applicable):	
Date of Birth:	
Medicare number:	

I accept and authorise:

____(previous practice name)
to release Healthcare information of the patient named above to:

Practice Name: **Health on Central**
Address: **26 Central Drive**
ANDERGROVE QLD 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 alternatively you can send through secure messaging using 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*****