PO BOX 169
Ballan VIC 3342
info@keeleyscause.org.au
ABN: 29 145 766 216

Medical Release Authorisation Form

Patient Name: .... Date of Birth: ....

The above named person must indicate when this authorisation is to expire:

- ☑ In six months
- ☐ In one year
- ☐ On date
- ☐ In three years

The person named above hereby authorises

- ☑ Request health information from
- ☑ Send health information to
- ☑ Discuss health information with

The person named above authorises information to be requested or released by representatives of

Name: Keeley's Cause – ABN 29 145 766 216
Address: PO Box 51, Ballan, Victoria, 3342
Phone: 0412 819 110

Scope

☑ All information regarding assessment and diagnosis.

....

☐ All information regarding care received by patient between the dates of

.... and ....
Starting Date — Ending date

☐ Other information (specify): ....

....

Authorisation

....
Printed name of Patient or Authorised Representative

....
Signature of Patient or Authorised Representative | Date | Signature of witness | Date

If not signed by the patient, indicate relationship of authorising person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient

believe in your dreams
OUR DISABILITY WILL NEVER DEFINE OUR ABILITY