# 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 169, Ballan, Victoria, 3342 | | | | | | | | | |
| Phone: | 0412 819 110 | | | | | | | | | |
| **Scope** | | | | | | | | | | |
| 🗹 | All information regarding clarification of 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 | | | | | | | | | |