# 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 |