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 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