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

believe in your dreams

OUR DISABILITY WILL NEVER DEFINE OUR ABILITY