



UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Release of information request form

Details of Patient:

Surname:	Given names:	
Name when last attended hospital: (If different to current name)		
Address: (Past address if applicable)	Postcode:	
Telephone:	Date of birth:	

Information to be released to:

Name:		
Relationship to patient:		
Hospital/Organisation:		
Postal address:	Postcode:	
Telephone/Pager:	Fax:	
Preferred method: (tick)	<input type="radio"/> Phone <input type="radio"/> Fax <input type="radio"/> Mail <input type="radio"/> RCH Link <input type="radio"/> My RCH Portal	
Date required: (Allow two working days for processing)	/ / 20__	

Information required: Specify information required (eg. specific diagnosis, test)

<input type="radio"/> Discharge summary:	
<input type="radio"/> Outpt/correspondence:	
<input type="radio"/> Investigations Results:	
<input type="radio"/> Other, please specify: (eg. clinical summary)	

Patient consent to release of information: Provided: (please tick) Below or Separate

(Request will not be processed without written consent of the patient, parent, guardian or person responsible for patient)

I, authorise the release of my (or my child's) relevant health information as specified above.

I understand I may revoke this consent at anytime except to the extent that action has already been taken on it.

Signature: _____ Print name: _____ Date: _____

(Patient, Parent, Guardian or Person Responsible for Patient)

Please forward this form to:

The Royal Children's Hospital
Health Information Services
Flemington Road
Parkville 3052
Phone: 9345 6107 Fax: **9345 6589**

FOR INTERNAL USE ONLY UR Number:	Request received by:	Date:
	Request processed by:	Date:

Consent: Above or Attached

Release of information request form MR45/C