The Royal Children's Hospital Melbourne

| 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) | ○ Phone Fax Mail Parkville Connect My RCH Portal | | |
| Date required: (Allow two working days for processing) | / / 20___ | | |

| **Information required:** | Specify information required (eg. specific diagnosis, test) |
|---|---|
| ○ Discharge summary: | |
| ○ Outpt/correspondence: | |
| ○ Investigations Results: | |
| ○ 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**
Email: **HIS.Patientinfo@rch.org.au**

FOR INTERNAL USE ONLY
UR Number:
Consent: ○ Above or ○ Attached

**Verbal Consent:** (Clinician use only)
(Verbal consent should only be used where it is not practical to obtain written consent)
I have discussed with the following patient/ guardian ............................................ how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent to share the information detailed above has been given.

Clinician name: ______________________ Role: ______________
Clinician signature: Date:

Request processed by: Date:

Release of information request form MR45/C



October 2021