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 ◯ RCH Link ◯ 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**

FOR INTERNAL USE ONLY UR Number: Consent: ◯ Above or ◯ Attached	Request received by:	Date:
	Request processed by:	Date:

November 2016

Release of information request form MR45/C