The Royal Children's Hospital

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 provided to:

Name:			
Relationship to patient:			
Hospital/Organisation:			
Postal address:		Postcode:	
Telephone/Pager:		Fax:	
Preferred method: (tick)	Phone ☐ Fax ☐ Mail ☐	Date required: / / 20___ (Allow two working days for processing)	

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

Discharge summary: ☐	
Outpt/correspondence: ☐	
Investigations results: ☐	
Other, please specify: ☐ (eg. clinical summary)	

Patient consent to release of information: **OR: ☐ I am registered on this patient's recent RCH records***

(Unless you are recorded at RCH as a healthcare provider for this patient within the past 12 months*, we need the written consent of the patient if over 18 y.o., parent, guardian or person responsible for patient).

I, (print full name) ..... (*please select*: the parent/guardian/patient over 18 years old), authorise the release of my (or my child's) relevant health information as specified above.

I understand that this consent is valid for one year. I can change my mind at any time by contacting the hospital directly, providing the information has not yet been sent.

Signature: _____ Date: _____

Please fax this form to: **Fax: (03) 9345 6589** Phone: (03) 9345 6107 or a/hours (03) 9345 6114	Or by post: The Royal Children's Hospital Health Information Services Flemington Road Parkville 3052

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

August 2005

*For more information: www.rch.org.au/kidsconnect

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