

# Request for Release of Patient Information

Send completed form to Health Information Services via:

Email: [TPCH-MRD-ROI@health.qld.gov.au](mailto:TPCH-MRD-ROI@health.qld.gov.au) **OR** Fax: 07 3139 4908**CONFIDENTIAL COMMUNICATION****REQUESTING PERSON NAME:****Designation:****Signature:****Facility:****Phone:****Fax:**

- ☐ **URGENT**  
**WITHIN 2-4 HOURS**  
☐ Resus ☐ Emergency
- ☐ **AS SOON AS POSSIBLE**  
**WITHIN 24 HOURS**  
☐ OPD / SOPD / Other
- ☐ **WITHIN 24-48 HOURS**  
☐ GP / Medical Centres

[ INDICATE APPOINTMENT DATE: \_\_\_\_\_ ]

(Write patient details or affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ I**CONSENT TO RELEASE INFORMATION**

I, \_\_\_\_\_

(patient/client/guardian) – date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

hereby consent to the release of clinical information to my healthcare professional for my ongoing care and treatment.

Signature: \_\_\_\_\_

The Hospital and Health Boards Act (2011) states that patient information may only be divulged to another health care provided if that person is directly involved in the care of the patient. Information provided in circumstances where the patient is unable to consent (for example in a case of emergency or if the patient is unconscious) will be justified on the basis of implied consent or necessity. In non-emergency situations where a person is fully conscious and able to consent, release of patient information without signed patient consent may amount to a breach of confidentiality.

**Is the information required for ongoing care and treatment?** ☐ Yes ☐ No**INFORMATION REQUIRED**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Discharge summary   | <input type="checkbox"/> CABG (with d)   | <input type="checkbox"/> CTPA/CTCA    |
| <input type="checkbox"/> ED clinical summary | <input type="checkbox"/> MVR/AVR/other   | <input type="checkbox"/> CXR/XR/other |
| <input type="checkbox"/> Psych summary       | <input type="checkbox"/> CCR/CDR (angio) | <input type="checkbox"/> MRI/MRc      |
| <input type="checkbox"/> Letters             | <input type="checkbox"/> PPI/BVcdi       | <input type="checkbox"/> U/S          |
| <input type="checkbox"/> Path/Histo          | <input type="checkbox"/> ICD check       | <input type="checkbox"/> CT           |
| <input type="checkbox"/> Gastro/Colo         | <input type="checkbox"/> TTX             | <input type="checkbox"/> TOE          |

**Other information:**

This facsimile is a confidential communication between the sender and the addressee. The contents may also be protected by legislation as they relate to health service matters. Neither the confidentiality nor any other protection attaching to this facsimile is waived, lost or destroyed by reason that it has been mistakenly transmitted to a person or entity other than the addressee. The use, disclosure, copying or distribution of any of the contents is prohibited.

If you are not the addressee please notify the sender immediately by telephone or facsimile number provided above and return the facsimile to us by post at our expense.

