

**APPLICATION / CONSENT TO RELEASE CLINICAL NOTES/HEALTH INFORMATION**

**Patient/Client Details to whom the records relate:**

Surname:		First Name:	
Date of Birth:		Previous Names:	
Current Address:			
Address at time of treatment:			
Home phone:	Mobile:	Work:	

**Are you the patient/client?**     **Yes**  
 **No** - state your relationship to the patient: \_\_\_\_\_

Applicant's Surname:		First Name:	
Current Address:			
Home phone:	Mobile:	Work:	

**Type of Access Required:** (please tick appropriate box)  
 Copies of documents       View records only at facility

**State specific information you require** – includes dates or approximate dates of attendance:

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**Held at which health facility?**

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**State purpose for which you require the information:**

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**Identification Required:** 2 forms of identification that contain a signature only    **OR**  
1 form of identification that contains a photo and signature

**Fees:**      **\$33.00** for copy of notes plus **41 cents per page (+ GST)** when over 80pages

**Signature of Applicant:** \_\_\_\_\_ **Date** \_\_\_\_\_

<b>Office Use only:</b>	
Date Received: _____	Fees Paid? <input type="checkbox"/> In full <input type="checkbox"/> Partial <input type="checkbox"/> No Date
entered onto register: _____	ID Sighted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Copies of ID destroyed? <input type="checkbox"/> Yes <input type="checkbox"/> No   Signature: _____	