ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

Release of information form – clinical record

Patient details: - person whose records are to be accessed	
Surname:	NHI:
Given names:	DOB: / /
Also known as:	
Residential address:	

Requestor details:
Name:
Relationship to patient:
Postal address:
Contact phone numbers:

Authority to request this information:	**Supporting copies attached of:**
☐ I am the patient	☐ photo identity
☐ I am the parent / guardian of the child who is under 16 years of age	☐ photo identity (proof of relationship may be required)
☐ I have written consent from the patient	☐ photo identity & written consent
☐ I have lawful authority (e.g. power of attorney) over the person's affairs	☐ photo identity & lawful consent
☐ I have authorisation from the executor of the deceased person's estate	☐ photo identity & lawful authority

Information requested: select the categories of information requested	
Clinical record	Date range:
Other (please specify)	Date range:

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Request to be actioned by:
In compliance with the Privacy Act, we will respond to your request no later than 20 working days from date of receipt. If you require your documents before this timeframe, please indicate the date below and the reason for urgency. We will make every effort to meet your requirements – but this may not always be possible. We will communicate with you should we not be able to meet your requested timeframe.
Date required by (urgent requests only):
Reason for urgency:

Delivery details:
☐ Mail/courier to address above ☐ Collect from Clinical Records Department or Main Reception
☐ Send electronically to this email address:_____

Requestor signature:_____Date of request:_____