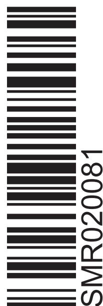
NSW GOVERNMENT | Health

Facility:



SMR020081

CONSENT TO OBTAIN HEALTH INFORMATION FROM EXTERNAL AGENCIES

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / ______	M.O.	
ADDRESS		
LOCATION / WARD		

EXTERNAL SERVICE

To: ____________________

Address: ____________________

Telephone: ____________________ Fax: ____________________

Name: ____________________ **DOB:** ____________

The above named has stated that he/she was a patient under your care or client of your service. Below is a signed authority requesting details of his/her history and treatment in relation to his/her:

Details of information required: Date Range:

____________________ ____________

____________________ ____________

____________________ ____________

Urgency of Request (please tick): ☐ Urgent (1 business day) ☐ Semi-urgent (2 business days) ☐ Routine (5 business days)

PATIENT AUTHORITY

I hereby give permission for the ____________________ (Local Health District / Health Care Provider) to obtain verbal and written information regarding the medical/treatment/hospitalisation/other care provided by

____________________(name of external service provider/facility).

A photocopy of this authorisation shall be considered as effective and valid as the original.

Patient Name: ____________________ DOB: ____________

☐ Consent is not able to be obtained because patient is too unwell

Signature: ____________________ Date: ____________

Witness Name: ____________________ Signature: ____________ Date: ____________

Parent/Guardian/Carer Name: ____________________ Relationship: ____________

Signature: ____________________ Date: ____________

Permission is given until I withdraw my authority in writing for the following period from the date of this authority (please tick):

☐ 3 months ☐ 6 months ☐ 12 months ☐ 2 years.

*If the patient is **16 years old and over**, the patient's own consent is sufficient. If the patient is aged between **14 and 16 years old**, they can provide consent provided they adequately understand and appreciate the nature and consequences of the consent. Wherever possible the practitioner should also obtain the consent of the parent or guardian unless the patient objects. If the patient is **under 14 years old**, consent of the parent or legal guardian must be obtained.*

REQUESTING HEALTH SERVICE

Please respond to this request by either emailing, posting or faxing the patient information as soon as possible to:

Service/Department Name: ____________________

Postal Address: ____________________

Telephone: ____________ Fax: ____________ Email: ____________

REQUESTING HEALTH SERVICE - OFFICE USE ONLY

Completed By:

Staff Name: ____________________ Date: ____________ Time: ____________

Signature: ____________________ Designation: ____________________

Faxed By:

Staff Name: ____________________ Date: ____________ Time: ____________

Signature: ____________________ Designation: ____________________

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH606592 200214

CONSENT TO OBTAIN HEALTH INFORMATION FROM EXTERNAL AGENCIES

SMR020.081

NO WRITING