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**Application to Release Medical Information – Private and Confidential**

This form can be used when requesting the release of medical information of a client of Danila Dilba Health Service. All relevant fields must be completed and emailed to roi@ddhs.org.au

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| **Client Information** |
| **Full Name:** | **Date of Birth:** |
| **Address:** | **Email:** |
| **Mobile:** | **Phone:** |

Danila Dilba Health Service requires proof of identity of the requester. Please attach an official form of identification (e.g drivers license). If applying in person, you may produce your identification to a staff member for sighting.

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| **Requesting Party (if different to above details)**  |
| **Full Name:** | **Organisation:** |
| **Phone:** | **Email:** |

Information RequestedPlease select one option from the table below information authorised for release.

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| --- | --- | --- |
| **Information Requested:** | **Details:** | **Please Tick**  |
| Client SummaryNo cost to client\*\* | For continuing client care purposes. *Please select this option if you are another Health Care Service provider* *\*\*This option is NOT available for legal, solicitor, insurance and other third parties* |  |
| Medical Record Summary($130 + GST) | This includes current medications, immunisations, recalls and a clinical summary. |  |
| Medical Report($395 + GST) | This includes requests for GP reports and Mental Health reports. |  |
| Health Record($395 + GST) | This includes the Medical Record Summary (as above) with the addition of progress notes. |  |
| Detailed Health Record($495 + GST) | Full Medical record – all progress notes, interactions, results, medications plus all documents held on file. This also includes requests for records within set date ranges and/ or regarding identified diagnosis.Please advise the date range of which you are requesting the information for.Start Date: …………End Date: …………Other (e.g specific injury / condition): ………………………… |  |

Client Consent for Release of Information

I attach a signed authority and (where relevant) details of legislative basis for the request (e.g *Care and Protection of Children Act*)

***OR;***

***I;***

 **Client**

 **Parent / Guardian**

**(enter full name and date of birth) ……………………………………………………... consent to the party listed above obtaining my medical information held by Danila Dilba Health Service. I understand that charges may apply to this application and agree to pay within 30 days of receipt.**

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| **Signature:** | **Date Consent Provided:** |
| **Witness:** | **Signature:** |