



Queensland  
Government

Metro North Hospital and Health Service

## CONSENT TO RELEASE / OBTAIN INFORMATION

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ I

Section 144 of the Hospital and Health Boards Act (2011) states that a designated person may disclose confidential information if the person to whom the confidential information relates is an adult and consents to the disclosure or if a child the child's parent or guardian consents to the disclosure. Section 145 of the Hospital and Health Boards Act (2011) states that a designated person may disclose confidential information if the disclosure is for the care or treatment of the person to whom the information relates. In non-emergency situations where a person is able to consent, release of patient information without signed patient consent may amount to a breach of confidentiality.

### PATIENT/GUARDIAN TO COMPLETE

Patient name: ..... Date of birth: ..... / ..... / .....

I, ..... (print name)

of .....

(address)

Relationship to patient: (if applicable)

give permission for (specify name of service) .....

(indicate any special conditions for release such as through Medical Office, Case Manager, Social Worker):

To ☐ Provide and / or ☐ Obtain the following information relevant to my assessment or treatment:

(Tick as many as applicable – please provide details legibly)

<input type="checkbox"/>	Discharge summaries	
<input type="checkbox"/>	Operation / anaesthetic reports	
<input type="checkbox"/>	Medical notes	
<input type="checkbox"/>	Results / tests	
<input type="checkbox"/>	Letters	
<input type="checkbox"/>	Special instructions (please specify)	
<input type="checkbox"/>	Other (please specify)	

☐ From and / or ☐ To: (specify name of service where information is located and/or recipient of information)

Name	Address	Phone	Fax

This consent is valid: ☐ Until treatment is completed  
☐ Continuously (no time limit)  
☐ For ..... months

Patient / Guardian (sign): ..... Date: ..... / ..... / .....

Witness (print name): ..... Signature: ..... Date: ..... / ..... / .....

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying  
All clinical form creation and amendments must be conducted through Health Information Services

MR 61430

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OfficeMax



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