Consent for Release of Information

Please note: Requests are processed within 30 days of receipt. If your request is urgent, please provide supporting information at the time of lodgement and we will endeavour to prioritise before other requests.

We can only commence processing completed forms that are accompanied with photo ID.

Thanking you, the Privacy team (email: privacy@icon.team / phone: 3737 4582)

SECTION 1 – Patient Details

Surname: _____ **Given Names:** _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Phone Number: _____ **Date of Birth:** _____

SECTION 2 – Details of information requested

☐ Consult Letters ☐ Consult Notes ☐ Pathology ☐ Radiology

☐ Chemotherapy ☐ Progress Notes ☐ Radiation Treatment

☐ Other (Please specify): _____

SECTION 3 – Receiving party (please indicate who will be receiving the information)

☐ Patient ☐ Medical Practitioner ☐ Solicitor ☐ Insurer

☐ Other (please specify): _____

Receiving Party Name: _____ **Phone:** _____

Email Address: _____ **Fax:** _____

SECTION 4 – Authority to Release Information

I _____ (print name) authorise release of requested information.

Signature: _____ **Date:** _____

Please sign with BLACK pen & enclose a copy of your photo ID (drivers' licence or passport)

SECTION 5 – Authorising party (only applicable if patient is unable to give / communicate consent)

Reason for patient being unable to give consent: _____

Name of authorising party: _____

Relationship to patient: ☐ Parent / Guardian (child under age 16)

☐ Power of Attorney (copy required)

☐ Executor of the Estate (copy of Will required)

Signature of authorising party: _____ **Date:** _____

Please sign with BLACK pen & enclose a copy of your photo ID (drivers' licence or passport)