

RELEASE OF INFORMATION AUTHORISATION FORM



Mail, fax or email this form to:

MSI Australia GPO Box 1635 Melbourne VIC 3001 Australia

Fax: +61 3 9658 7579 | Email: ISTP@msiaustralia.org.au

Application Details

This application is for both Client and Third Party requests. Third Party requests are those acting on behalf of the client and must complete all sections.

Client Details

Surname:	
Given Name:	
Date of Birth:	
Address:	
Phone Number:	
Email Address:	
MRN (if known): MSI Australia Health record number	

Applicant Details (if different from above)

Surname:	
Given Name:	
Address:	
Phone Number:	
Email Address:	
Relationship to client:	

Information Required from the Health Record

- Copy of Entire Health Record **OR** Copy of Pathology (please specify) _____
- Copy of Ultrasound Photo
- Other (please specify) _____

Date(s) of Admission: (if known)	
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Name of Clinic:	
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For **Translation or Interpreter Services** to complete this form, please contact the Translating and Interpreting Service (TIS) on 13 14 50 and ask them to call MSI Australia

RELEASE OF INFORMATION REQUEST AUTHORISATION FORM



Fees and Charges

An invoice will be sent via email upon acknowledgement of your request with information on how to pay.

Fees **MUST BE PAID** prior to release of information. Please **do not forward payment** until the fees are confirmed by the Health Information Team:

Application fee applies unless waived, please refer to exemption criteria below.

Criteria for exemption:

- Under 18 years of age
- Aboriginal, Torres Strait Islander and/or South Seas Islander person (supported on registration form)
- Refugee/seeking asylum
- Healthcare card holder (copy required)
- Other pension (copy required)

Application Fee	\$38.20
Physical copy of medical record <i>(plus application fee and postage fee advised on application)</i>	\$0.20/page

Authority for Release of Information

Request for Information – Client

Client Signature _____ Date _____

- Copy of Photo Identification e.g. driver's license **or** passport
- Copy of Health Care Card **or** other documentation for exemption (if applicable)

Request for Information – Third Party

*The client must sign this authority **or** you must provide evidence that you have the authority to access this information on behalf of the client.

I, _____ of _____
(Client Name) *(Address)*

hereby authorise MSI Australia to release information to _____
(Applicant Name)

as requested above.

Client Signature _____ Date _____