



Form

Document Number: GCQ-FRM-0004

Effective Date: 12-Jan-2021

Request for Release of Client Health Information

Please complete this request to access a client health record and return to privacy@blackswanhealth.com.au
This form must be signed by the client or guardian in the case of the client being under 16 years of age.

Name on Client File:	
Client DOB:	
Address:	
Postal Address:	
Email:	

Name of requestor:	
Requestor Address:	
Requestor Contact No:	<input type="checkbox"/> Mobile: <input type="checkbox"/> Other: email:
Relationship to Client:	<input type="checkbox"/> Self <input type="checkbox"/> Relationship:
The following certified copy or original documents will be requested before request is processed: * if not self-requestor, evidence to prove your relationship with the client (e.g. birth certificate) * power of attorney or guardianship if you are the legal guardian of a client who is over 18 years of age * at least one of the following Photo ID: current Driver's Licence or current passport	

Information requested:	
File access method being requested: *Note: a postage and administration fee may be charged ** Note: report writing fee may be charged	<input type="checkbox"/> View of client health record <input type="checkbox"/> Have the client health record explained onsite <input type="checkbox"/> Photocopy of client health record * <input type="checkbox"/> Summary Report**
Service/ Program accessed:	
Service location:	

Please note release of information may take up to 30 days

By signing below, I give permission for the one-off specified release of my client health record. I confirm that the information provided on this form is true and correct to the best of my knowledge and belief.

Signature: _____
(Client - or Parent/ Guardian if under 16)

Date: ___ / ___ / _____

Name: _____
(Parent or Guardian if under 16)