

## Request for Release of Client Information Form

Please complete this request to access a client health record and return to [privacy@blackswanhealth.com.au](mailto: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.

<b>Full Name on Client File:</b>			
<b>Client Date of Birth:</b>			
<b>Address:</b>			
<b>Postal Address:</b>			
<b>Email:</b>			
<b>Phone Number:</b>			
<b>Name of requestor:</b>			
<b>Requestor Address:</b>			
<b>Requestor Contact No:</b>			
<b>Relationship to Client:</b> <u>Please note identification documents required to be forwarded with completed form before request can be processed</u>	<input type="checkbox"/> <b>Self: Photo ID:</b> current Driver's Licence or current passport OR <input type="checkbox"/> <b>Other-Relationship to client::</b> _____ • If parent: Please provide evidence to prove your relationship with the client (e.g. birth certificate) OR • <b>Documentation certifying</b> legal guardianship / <b>other of a client</b>		
<b>If the document(s) are to be sent to someone else on your behalf, please advise their details:</b>  <b>ALSO SEND A COPY TO ME</b> <input type="checkbox"/>	Name: Relationship: Postal Address: Phone Number: Email:		
<b>Information requested:</b>			
<b>File access method being requested:</b> *Note: a postage and administration fee may be charged ** Note: report writing fee may be charged	<input type="checkbox"/> View client record <input type="checkbox"/> Have the client record explained onsite <input type="checkbox"/> Photocopy of client record * <input type="checkbox"/> Summary or other prepared Report** <input type="checkbox"/> Other: please describe:		
<b>Service/ Program accessed:</b>			
<b>Service location:</b>			

**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)

BSH Privacy Policy Statement may be accessed on the [Black Swan Health Website](#)