

Release of Information Request/Consent Form

Health Information Department

Ph: (02) 8425 3085 Fax: (02) 8425 3034



North Shore
Private Hospital

Part of Ramsay Health Care

To release information to you from your medical records at NSPH, please complete the following form.
The Health Information department will check your signature against that in the medical record.

*DETAILS OF PATIENT

Surname: _____

Given Names: _____ DOB: _____

Previous Name (e.g. Maiden Name): _____

Address: _____

Contact Number: _____ Email: _____

*INFORMATION REQUESTED

☐ Discharge summary

☐ Medications

☐ Other information (please specify): _____

*Reason for information is required:

☐ For further operation

☐ Doctor consultations

☐ Other reasons (please specify): _____

DOCTOR

If you wish the information to be sent to your doctor please provide details.

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email: _____

*PATIENT AUTHORITY:

I, _____ hereby authorise the release of my medical information as specified above.

Signature of Patient: _____

Print Name: _____ Date: _____

To complete the release of information please:

- Include a photocopy of identification which contains your signature (attach on next page), except the information that is sent directly to the hospital or doctor
- Fax completed form with copy of your ID to **(02) 8425 3034**
- Post completed form with copy of your ID to:
**Medical Records Dept
North Shore Private Hospital
Locked Bag 1008
St Leonards NSW 2065**
- Email this form, please click [here](#)

Please be advised there may be cost associated with providing a completed copy of your medical records.
Please phone (02) 8425 3085 if you have any questions regarding this request.

Attach ID Here