Queensland Government

Children's Health Queensland Hospital and Health Service

Consent / Request for Release of Patient Information

(LCCH USE ONLY – Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

- Please complete and either scan and email to: **CHQ_HIA@health.qld.gov.au** *or* fax to: **07 3068 4809**
- For further information or urgent requests contact Health Information Access on **07 3068 5372** / **07 3068 1348**

Patient Details

Surname:	Given name/s:	Sex	DOB
		F	

Person Requesting Information

Title: Dr **Name:**

Hospital / Surgery:

Phone no: **Fax no:** **Date of request:**

When is the information required?

If a medical emergency, phone immediately

Information required *Tick as many as applicable. Please provide details legibly.*

☐	Discharge Summaries	
☐	Operation / Anaesthetic Reports	
☐	Progress Notes	
☐	Results	
☐	Letters	
☐	Other	
☐	Special instructions	

Medical Officer signature: **Date:**

CONSENT TO RELEASE OF INFORMATION (to be completed by patient / client / guardian)

I, ... [patient/client/guardian] hereby consent to the release of clinical information from my Children's Health Queensland medical record to the above named healthcare professional who is currently directly involved in my ongoing care.

Signature: **Date:**

Section 145 of the *Hospital and Health Boards Act (Qld)* states that patient information may only be provided to another health care professional if that person is directly involved in the care of the patient. Information provided in circumstances where the patient is unable to consent will be justified on the basis of implied consent or necessity. For example, in a case of an emergency or if the patient is unconscious. In non-emergency situations where a person is able to consent, release of patient information without signed patient consent may amount to a breach of confidentiality.

OFFICE USE ONLY **INFORMATION RELEASED:**

CHQ UR number:	Record location:
☐ Discharge Summaries:	☐ Procedures:
☐ Letters:	☐ Pathology:
☐ Radiology:	☐ OPD / DEM:
☐ Other:	
Sent by: ☐ Telephone ☐ Mail ☐ Fax Released by:	Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

CONSENT / REQUEST FOR RELEASE OF PATIENT INFORMATION

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