



# Consent for Release of Information

**Please note:** Requests are processed within 30 days of receipt. If your request is urgent, please provide supporting information at the time of lodgement and we will endeavour to prioritise before other requests.

**We can only commence processing completed forms that are accompanied with photo ID.**

Thanking you, the Privacy team (email: [privacy@icon.team](mailto:privacy@icon.team) / phone: 3737 4582)

## SECTION 1 – Patient Details

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## SECTION 2 – Details of information requested

☐ Consult Letters ☐ Consult Notes ☐ Pathology ☐ Radiology

☐ Chemotherapy ☐ Progress Notes ☐ Radiation Treatment

☐ Other (Please specify): \_\_\_\_\_

## SECTION 3 – Receiving party (please indicate who will be receiving the information)

☐ Patient ☐ Medical Practitioner ☐ Solicitor ☐ Insurer

☐ Other (please specify): \_\_\_\_\_

Receiving Party Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax: \_\_\_\_\_

## SECTION 4 – Authority to Release Information

I \_\_\_\_\_ (print name) authorise release of requested information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign with BLACK pen & enclose a copy of your photo ID (drivers' licence or passport)

## SECTION 5 – Authorising party (only applicable if patient is unable to give / communicate consent)

Reason for patient being unable to give consent: \_\_\_\_\_

Name of authorising party: \_\_\_\_\_

Relationship to patient: ☐ Parent / Guardian (child under age 16)  
☐ Power of Attorney (copy required)  
☐ Executor of the Estate (copy of Will required)

Signature of authorising party: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign with BLACK pen & enclose a copy of your photo ID (drivers' licence or passport)