CONSENT FOR THE RELEASE OF PATIENT INFORMATION

PRIVATE & CONFIDENTIAL

*Note: ID should also be provided by your nominated representative

Patient Details

First name: _____

Surname: _____

Phone: _____

Address: _____

_____

Records being Requested

Prescription ☐ Test result ☐ Medical Records ☐

Authorisation for Release of Patient Information

I_____ hereby request for my records, as detailed above, to be released to *myself* (delete if not applicable) OR with my consent to:
If transferring to another GP, please confirm the name and address of receiving GP.
Name: _____

Address: _____

Name: _____

Address: _____

I enclose a copy of my passport/driver's license as proof of identity* ☐
I enclose a fee of €_____(if applicable) ☐

I authorize the release of my medical records as indicated above.

Signed: _____

Date: _____

Understanding My Rights as a Patient

1. I understand the release of the records will no longer preserve the confidentiality of my records and the information contained therein.

2. I understand that this authorisation is voluntary. Treatment, payment enrolment or eligibility for benefits may not be conditioned on my signing this authorisation except if the authorisation is for:

a) Conducting research-related treatment.
b) To obtain information in connection with eligibility or enrolment in a health plan.
c) To determine an entity's obligation to pay a claim.
d) To create health information to provide to a third party.

3. I understand that I may revoke or alter this authorisation at any time, that I do so in writing and submit it to Centric Health. However, I understand if I revoke this authorisation, it will not have any effect on the actions Centric Health took before they received my revocation.

4. Once this health information is disclosed, how the recipient further discloses may no longer be protected under data protection legislation or by Centric Health.

5. I understand that I am entitled to request and receive a copy of this authorisation.

Proof of Patient Authentication

Photo ID ☐ Signed consent ☐
Spoke to the patient directly ☐

Signature of a staff member who carried out patient authentication:

Name: _____