SPECIALIST
EYE SURGEONS

1/38 Margaret Street, Moonee Ponds, 3039
Phone (03) 93727022 | Fax (03) 9372 7044
E: contact@specialisteyesurgeons.com.au
W: specialisteyesurgeons.com.au

Authorisation to Release Medical Records

Name of Patient:

Date of Birth :

I, the undersigned, authorise the release of my medical information.

Please provide the following:

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

FROM: Specialist Eye Surgeons
1/38 Margaret Street, Moonee Ponds
VIC, 3039
P: 9372 7022
F: 9372 7044

TO: **Name:**
Address:

P:
F:

I understand that my records are confidential,protected by Australian privacy laws, and cannot be disclosed without my written authorisation, except when otherwise permitted by law. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorisation in writing at any time.

The authorisation will expire six (6) months from the date of my signature, unless I revoke the authorisation prior to that time.

Date: _____ **Signature:** _____
Patient or Legally Authorised Representative

_____
Name of patient or Legally Authorised Representative