CDACLINICS

Authority to Release Health Information

Date: _____

Dear: _____

Address: _____

Fax: _____

Patient Full Name: _____

DOB: _____

The above patient is attending CDA Clinics and requests transfer of their complete medical history including:

- ☐ Health Summary
- ☐ Reports
- ☐ Clinical Notes
- ☐ Pathology
- ☐ Discharge Summaries
- ☐ Care Plans
- ☐ Health Assessments
- ☐ Mental Health Care Plans
- ☐ Medical Imaging

This is a signed authority for you to release my health information as specified above.

I, _____ understand an administration fee may be charged for this
(name)

service and this is the responsibility of myself. If you charge a fee for the transfer of files, please contact me directly on _____
(phone number)

Patient Full Name: _____

Signature: _____

OUR PREFERRED FORMAT FOR RECORDS IS ELECTRONICALLY
VIA MEDICAL OBJECTS OR FAX TO (02) 9167 7191