Authority to release clinical information

Sexual Health Quarters

I (full name)_____ (DOB) _____
of (address)_____
hereby consent to staff at SHQ Clinic releasing information/reports concerning my medical, sexual and reproductive health history and investigation results including STIs and other relevant information to:

☐ Me
☐ Authorised Person
Suggested Categories of Authorised Persons:

- Lawyer acting on behalf of the client/patient.
- Guardian – authorised by the State Administrative tribunal.
- Power of Attorney – registered on a legal document.
- Health Practitioner – involved in the ongoing care of the client/patient.
- Family Member

Name and contact Details of Nominated Recipient/s above
_____

Details of information requested (eg. Date(s) of attendance, service area attended, type of document requested (e.g., test results, summary))
_____
_____
_____
_____

Client Signature_____ Date: _____

If you have changed your name or use an alias, please include all known names to assist with locating your records.

The above authority is valid for 12 months post date

Note Regarding Client Confidentiality

SHQ complies with the Privacy Act 1988 (2017) and is committed to protecting client privacy. Our Privacy Statement, available on our website, outlines clients' privacy rights. In certain circumstances, SHQ clinicians may be required to share information to protect the safety of the client or others. Unless it is an emergency, this will be discussed with the client beforehand.

Office Use Only

Application Date Received: _____
Client Record Authorised for Release: ☐ Yes ☐ No
Signature Medical Director: _____
Date: _____ Date released: _____
Contact Method: ☐ Mail _____ (details)
☐ e-mail _____ (details)

Released by (staff name & position): _____