Mercy Health
Care first

Mercy Health

UR No:	
Family Name:	
Given Name:	
DOB:	Sex:
Address: (if no UR)	
COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL	

CONSENT TO OBTAIN / RELEASE PATIENT INFORMATION

FMH401400

BINDING MARGIN – NO WRITING

Complete this section to release information to another organisation

I authorise _____ **(Service)** to release the following information:

- ☐ Discharge Summary Dated: ____ / ____ / ____
- ☐ Operation Report Dated: ____ / ____ / ____
- ☐ Other Information Required (please specify):

To: _____ (Service)

Address: _____

Telephone Number: _____ Fax Number: _____

Complete this section to release information <u>from</u> another organisation

I authorise the release of the following medical information:

- ☐ Discharge Summary Dated: ____ / ____ / ____
- ☐ Operation Report Dated: ____ / ____ / ____
- ☐ Other Information Required (please specify):

To: Doctor/Department: _____

Service: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Print Full Name: Patient / Parent / Guardian _____

Patient's / Parent / Guardian's Signature _____

Relationship to patient: _____ Date: ____ / ____ / ____

In-house, V2, 10/24

NO WRITING

CONSENT TO OBTAIN / RELEASE PATIENT INFORMATION COR 0020