

Authority for the Release of Personal Information

I,
(Full name of Patient)

of
(Address of Patient)

Hereby authorise

- Flinders Medical Centre Repat Health Precinct Noarlunga Hospital
 Intermediate Care Services and Aboriginal Health Mental Health Services

To release any personal/health information, relating to the treatment and care of:

Patient Name:
within the public health system to the following person(s):

1. (Name of applicant)	2. (Name of applicant)
.....
(Address)	(Address)
.....

This authority to release information will expire twelve months from date of signature.

Signature: Print name in full:

Signature of witness: Print name in full:

Date:

Please email the completed form to health.SALHNFOI@sa.gov.au OR Post to:
SALHN - Freedom of Information Office,
Flinders Medical Centre,
Flinders Drive, BEDFORD PARK 5042

For more information

SALHN - Freedom of Information Office,
Flinders Medical Centre,
Flinders Drive, Bedford Park SA 5042
Telephone: 8204 5514 Email: health.SALHNFOI@sa.gov.au



This document has been reviewed and endorsed by consumers.



Health
Southern Adelaide
Local Health Network