**AUTHORITY FOR THE RELEASE OF PERSONAL INFORMATION**

**I**,.................................................................................................................................................

*(Full name)*

**of** ...............................................................................................................................................

*(Address)*

**date of birth** ..............................................................................................................................

**contact phone number**.............................................................................................................

**authorise**...................................................................................................................................

...................................................................................................................................................

*(Name of SA Health Hospital(s), Local Health Network(s) or Health Provider(s))*

# to release any personal/health information held about me relevant to:

*(Please tick relevant box)*

# □ a request for an investigation into my treatment and care within the public health system.

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*(Provide or attach details outlining the specifics of the matter for investigation)*

□ **other**

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*(Provide or attach details of the nature and extent of information to be released)*

# to the Chief Executive of SA Health or departmental officers acting for or on behalf of the Chief Executive.

The information provided to the Chief Executive, or department officers acting for or on behalf of the Chief Executive, is only to be used for the above purpose.

# The authority to release information will expire:

*(Please tick relevant box)*

# □ when the investigation is complete.

**□ on the date of**...................................................................................................................

**Signature:** ............................................................................................................

Print name in full: ............................................................................................................

**Signature of witness:** ............................................................................................................

Print name in full: ............................................................................................................

Address: ............................................................................................................

**Date:** ............................................................................................................

Please return the completed form by email to: [HealthCE@sa.gov.au](mailto:HealthCE@sa.gov.au) or by post to: PO

BOX 287 Rundle Mall, Adelaide S.A. 5000

