Medical Records
Phone: (07) 4727 4395
Fax: (07) 4727 4153
Email: medical.records@matertsv.org.au

Locked Bag 1000
Aitkenvale BC
4814

Request to Release Patient Clinical Information

Date: _____ Date of Birth: _____

I, _____ hereby consent for the Mater Health Services North Queensland, to release clinical/medical information on

Myself/other: _____

Relationship: _____

Patient signature: _____

If patient unable to sign:

Requesting doctors name: _____

Requesting doctors signature: _____

Requestors Contact Details

Name of Health Care Facility: _____

Name: _____

Phone: _____

Fax: _____

Type of clinical information requested: _____

_____

_____

_____