AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:……

UR ____ Ph ____

Family Name

Given Names

Address

Date of Birth

Gender

Male ☐ Female ☐

REFUSAL OF INFORMATION RELEASE

XXX213

HEALTH INFORMATION

I hereby revoke any previous consent to release my health information to:

☐ Name ……..

(eg. Health Care Provider / organisation / individual)

Relationship to patient ……

(eg. local Dr, Solicitor, family member)

RESEARCH

☐ I do not want to be contacted about new research studies

PATIENT

Patient / MTDM* Name ……

MTDM relationship to patient …… Phone ……..

Signature …… Date ..... / ..... / ..... Time ……..

**Medical Treatment Decision Maker* (Contact Legal Support Services or Legal Office for additional information)

INTERPRETER

Professional interpreter used to obtain consent? ☐ Yes

If yes, Name of interpreter _____ ☐ In-person ☐ Telephone ☐ Video

STAFF - *Alfred Health representative to complete, where applicable*

Name …… Designation ……

Signature …….. Date …... / …... / …...

Return completed document to:

Health Information Services
PO Box 315, PRAHRAN, VIC, 3131
E: *HISClinicalRequests@alfred.org.au*

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