AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:……

UR ☐ Ph ☐

Family Name ☐

Given Names ☐

Address ☐

Date of Birth ☐ Sex ☐ Female ☐ Male ☐ Other

REFUSAL OF INFORMATION RELEASE

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

Name of **professional interpreter** (*if utilised*) ……

Professional interpreter organisation name .....

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

Name …….…… Designation ……

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

Return completed document to:

Health Information Services
PO Box 315, PRAHRAN, VIC, 3181
E: HISResults@alfred.org.au

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