Justice Health and Forensic Mental Health Network

CONSENT TO RELEASE HEALTH INFORMATION

SURNAME	MIN
OTHER NAMES	
D.O.B.	☐ MALE ☐ FEMALE
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Instructions for Use of this Form:

- For use when releasing health information from JHFMHN to another agency e.g. external/legal agencies
- This form is valid only if completed and signed by the patient
- This consent is **valid for three months from date of signature of the patient.**
- Legal agencies must apply in writing to the Health Information & Record Service and provide this consent

I, the undersigned, hereby give consent for JHFMHN to share confidential information contained within my health record with the agency/agencies below. I understand that this information may be of a sensitive nature, which may include sexual assault, drug and alcohol, HIV/AIDS, domestic violence, sexual health, mental health, genetics, IVF and artificial insemination programs and children at risk or any other information which I define or interpret as sensitive.

PATIENT DETAILS

Surname/Family Name*: _____ Title (Mr/s)*:_____

Given Names*: _____ Date of Birth*: ____/___/___

Previous Names Alias:_____

MIN/CIMS/MRN Number*: _____ Postcode:_____

Current Address/ Location/ Health Centre: _____

THIRD PARTY DETAILS

Name of Requestor: _____ Relationship to Patient*: _____

Organisation/ Agency*: _____

Phone Number*: _____

Fax Number*: _____

INFORMATION REQUESTED: **DATE RANGE:**

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient: _____ Date: ___/___/___

Parent/Guardian/Carer Name**: _____

Signature of Third Party: _____ Date: _____ / _____/ _____

If the patient is **16 years old and over, the patient's own consent is sufficient. If the patient is aged between **14 and 16 years old**, they can provide consent provided they adequately understand and appreciate the nature and consequences of the consent. Wherever possible the practitioner should also obtain the consent of the parent or guardian unless the patient objects. If the patient is **under 14 years old**, consent of the parent or legal guardian must be obtained.

Completed applications should be sent to:

Via Post:
Medico-Legal - Health Information and Record Service Justice Health and Forensic Mental Health Network
PO Box 150
Matraville NSW 2036

Via Email:
JHFMHN-MedicoLegal@health.nsw.gov.au

Via Fax:
(02) 9289 5014

Phone: (02) 9289 5168

* Mandatory details

Form must be scanned into JHeHS under Title: 4 Medicolegal Correspondence Category 4: Legal Correspondence