MIND OASIS CLINIC
Suite 3, Level 3, Strathfield Plaza,
11 The Boulevarde, Strathfield, NSW 2135
T: 02 9011 6800 | F: 02 9011 6822
www.mindoasis.com.au

Medical Record Release Consent Form

Our medical record release policy complies with the **Health Records and Information Privacy Act 2002 (NSW)**. For more information, please visit here. This form is to be **completed by our patients** only, for the purposes of releasing their medical record at Mind Oasis Clinic. Please email this completed form with the proof of identification to medicalrecord@mindoasis.com.au.

1. PATIENT DETAILS

Under the Privacy Act of 1988, the Health Records Act of 2001, and the Health Records and Information Privacy Act of 2002, proof of identification is required for the medical record release request.

A photocopy of the patient's Australian Drivers License or Australian Passport must be provided.

Full Name of Patient:	
Date of Birth of Patient:	
Address of Patient:	
Phone Number of Patient:	
Email Address of Patient:	

2. MEDICAL RECORD DELIVERY

Mind Oasis Clinic will only send the patient's medical records to 1. Medical professional (e.g. GP, Specialist or Allied Health Professional) or 2. Solicitor or Insurer.

I authorize Mind Oasis Clinic to send my medical record to: (Choose **ONE** only)

□ 1. My Medical Professional (e.g. GP, Specialist or Allied Health Professional)

Name of Clinic:	
Name of Health Professional:	
Phone Number of Clinic:	
Email address of Clinic:	
Fax number of Clinic:	
Delivery method:	(Choose **ONE** only) □ email or □ fax

□ 2. My Solicitor or Insurer:

Company name of Solicitor or Insurer:	
Contact Person:	
Phone Number of Solicitor or Insurer:	
Email address of Solicitor or Insurer:	
Fax number of Solicitor or Insurer:	
Delivery method:	(Choose **ONE** only) □ email or □ fax

3. MEDICAL RECORD DETAILS

What medical record would you like Mind Oasis Clinic to release? (Choose all that applies)

□ All of the consultation letters by my Psychiatrist

Psychiatrist Full Name: _____

□ All of the consultation letters by my Psychologist

Psychologist Full Name: _____

□ Others: _____

4. HOW LONG WILL IT TAKE?

Under the Health Records and Information Privacy Act 2002 (NSW), private health care providers are required to respond to your request within 45 days of receiving your request. We aim to process this request within 7 business days.

5. FEE FOR ACCESSING MEDICAL RECORDS

An administration fee is required for releasing medical records: $66 (GST incl.); Merchant surcharge applies. The fee is in accordance with the regulations under the Privacy Act 1988, Health Records Act 2001, and Health Records and Information Privacy Act 2002). If you have any questions or concerns in regard to the fees, please contact the relevant Health Information Services site.

I authorize Mind Oasis Clinic to charge the administration fee: (Choose **ONE** only)

□ a. I will be paying for the administration fee with a debit or credit card. I understand and agree that Mind Oasis Clinic will contact me to gather the card details.

□ b. My Solicitor or Insurer will be paying for the administrative cost for releasing my medical record. I understand that an invoice will be generated to the Solicitor or Insurer provided, and the medical record will be released to them once the payment is being received by Mind Oasis Clinic.

DECLARATION & SIGNATURE

- I give permission to Mind Oasis Clinic to release my medical records.
- I understand and accept that according to the *Health Records and Information Privacy Act (NSW)*, the release of the medical record is subject to exceptions under the Act. The exception not to release medical records includes the provision of the information would constitute a significant risk to the life or health of any individual.
- I understand the information I provided above **must match** the record in the system of Mind Oasis Clinic, otherwise Mind Oasis Clinic can refuse the request.
- I understand and accept that there could be possible privacy risks due to the use of email and electronic communications.
- I authorize Mind Oasis Clinic to use the credit card details provided below to debit the fees involved in the provision of the medical records.
- I understand that all medical records are in electronic format only.

Signature of Patient:	
If the patient is under 18 Signature of Parent / Guardian (If applicable):	
Date (DD MMM YY):	

FOR OFFICIAL USE ONLY

Record released on: (DD MMM YYYY)	
Method [via email or via fax]	
Actioned by our receptionist [Full Name and Signature]	