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

This form is to be completed by our patients only, for the purposes to release their medical record at Mind Oasis Clinic. This form authorises and consents to the release of medical records, as required under Health Records and Information Privacy Act (NSW). For more information, please visit here.

Patients are required to email the completed form to medicalrecord@mindoasis.com.au. Please allow 5-7 working days for us to process this request.

PATIENT DETAILS

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

MEDICAL RECORD DELIVERY

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

□ a. My Health Professional (e.g. GP or 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

□ b. 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

MEDICAL RECORD DETAILS

What medical record would you like us 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: _____

PAYMENT DETAILS

Administration cost for providing medical records: $66 (GST incl.); *Merchant surcharge applies.*

□ a. I will be paying for the administrative cost for releasing a medical record with the credit card details provided below (Visa, Master or AMEX)

Name on Card:	
Card number:	
Expiry (MM/YY):	
CVV (3 or 4 digits)	
Cardholder's Signature:	

□ 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]	