MEDICAL RELEASE FORM

Patient's Full Name: _____

Date of Birth: _____ Gender: _____

Authorisation and Consent:

I hereby authorize any healthcare provider, physician, hospital, clinic, laboratory, or other medical facility (collectively, the "Provider") to release and disclose to the undersigned individual or entity any and all medical records and information, including but not limited to medical history, examination, diagnosis, treatment information, and billing statements, related to the patient's care.

Purpose of Release:

This authorization is made for the purpose of allowing the undersigned to obtain, review, and use the patient's medical information for medical treatment, insurance, legal matters, or other purposes as permitted by law.

Scope of Information to be Released:

The information to be released may include records relating to mental health, drug and alcohol treatment, HIV/AIDS status, genetic testing, and other sensitive information except where prohibited by law. I understand that I have the right to revoke this authorization at any time by providing written notice to the Provider, except to the extent that action has already been taken in reliance upon this authorization.

Expiration and Revocation:

This authorization shall remain in effect until revoked in writing by me. I understand that revocation will not affect any disclosures made prior to receipt of the revocation. Unless revoked, this authorization will expire automatically upon completion of the purpose for which it was given.

Acknowledgement of Rights:

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy laws. I also understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my signing this authorization.

Release Recipient:

Name of Person or Entity Receiving Information: _____

Address: _____

Phone Number: _____

Signature and Authorisation:

Signature of Patient or Legal Representative: _____

Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

Contact Number: _____

This Medical Release Form is governed by and construed in accordance with the laws of Australia. Any disputes arising out of or in connection with this authorization shall be subject to the exclusive jurisdiction of the courts of Australia. The undersigned represents that they have read and fully understand the terms of this authorization, and that they are signing voluntarily and with full knowledge of its significance.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE

Signature: _____

WITNESS SIGNATURE

Signature: _____