Maaruma-Li
ABORIGINAL MEDICAL SERVICE
HEAL • FIX • MAKE BETTER

AUTHORITY TO RELEASE MEDICAL RECORDS

RELEASE FORM

MAARUMA-LI AMS

Maaruma-Li Aboriginal Corporation Aboriginal Medical Service
Address: 19 Little Timor St Coonabarabran, NSW 2357
Phone: 1300 153 634
Email:Reception@maarumaliams.org.au
ABN: 22 102 327 240

TRANSFER OF MEDICAL RECORDS

Previous Practice Name: _____
Treating Doctor: _____
Practice Address: _____
Phone: _____

PATIENT DETAILS

Full Name: _____
Date of Birth: _____
Medicare Number: _____
Address: _____
Phone: _____
Previous Practice Contact Number: _____

REQUEST

I, _____, authorise and direct my previous treating doctor, medical practice, health service and any relevant treating health professionals to disclose and transfer my medical records and relevant health information to Maaruma-Li Aboriginal Corporation Aboriginal Medical Service for the purpose of my ongoing healthcare, treatment, care coordination and continuity of care.

Please include:

□ Full medical history
□ Current health summary
□ Current medications
□ Allergies and alerts
□ Immunisation history
□ Pathology results
□ Imaging reports
□ Specialist reports
□ Chronic Disease Care Plans
□ Mental Health Treatment Plans
□ Aboriginal and Torres Strait Islander Health Check records (715)
□ Other relevant clinical information eg Justice Health information, DCJ

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PATIENT CONSENT

I authorise and direct the release of my medical records and relevant clinical information to Maaruma-Li Aboriginal Corporation Aboriginal Medical Service.

Patient Name (print): _____
Signature: _____
Date: _____
Date of Birth: _____
If signed by parent, guardian or authorised representative
Name: _____
Relationship to patient: _____
Authority to act: _____

Important Notice

Patients aged 16 years and over must provide their own consent unless there is lawful authority for another person to act on their behalf.

Transfer Method Preferred

□ Secure Messaging
□ Clinical Software
□ Hard Copy Collection

OFFICE USE ONLY

Date request sent: _____
Requested by: _____
Date records received: _____

Method received

□ Secure Messaging
□ Clinical Software
□ Hard Copy Collection

PRIVACY NOTICE

This authority is provided by the patient for the release and transfer of health information to Maaruma-Li Aboriginal Medical Service for the purpose of ongoing treatment and continuity of care.

Health information is managed in accordance with applicable privacy and health records laws including the Health Records and Information Privacy Act 2002 (NSW) and, where applicable, the Privacy Act 1988.

This consent remains valid until the transfer is completed unless withdrawn earlier in writing.

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ATTACH COPY OF ID

To protect your privacy and ensure the safe transfer of your medical records, proof of identity is required when submitting this form.
Please provide one of the following:
□ Australian Driver Licence
□ Medicare Card
□ Passport
□ NSW Photo Card
□ Centrelink Concession Card
□ Other Government Issued Identification

If submitting this form on behalf of another person, you must provide proof of identity and evidence of your authority to act on their behalf, such as:
□ Parent or Guardian identification
□ Guardianship Order
□ Power of Attorney
□ Other Legal Authority

PLEASE INSERT ID IN THE BOX

PLEASE INSERT ID IN THE BOX

OFFICE USE ONLY

ID sighted and verified by: _____
Type of ID: _____
Date verified: _____

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