Authority for the Release of Personal Information

General Form

I, (*Full name of Patient*) .....

of (*Address of Patient*) .....

date of birth ..... contact phone number .....

Authorise the **Southern Adelaide Local Health Network (SALHN)** to release any personal/health information held about me, relevant to an investigation into my treatment and care.

1. (*Full name*) .....

   (Address) .....

2. (*Full name*) .....

   (*Address*) .....

This authority to release information will expire twelve months from date of signature.

Signature: .....

Print name in full: .....

Signature of witness: .....

Print name in full: .....

Address: .....

Date: .....

Please email this completed form to *HealthSALHNConsumerAdvisory@sa.gov.au*

For more information

Consumer Advisory & Privacy Services
Office of the Chief Executive Officer
Southern Adelaide Local Health Network
Flinders Medical Centre
Bedford Park SA 5042

Interpreter

Government of South Australia

Health
Southern Adelaide
Local Health Network