Consent for Release of Patient Information

Internal Information

Private and Confidential

Patient Details

Name: _____

Address: _____

_____

Phone:

Home: _____

Mobile: _____

Records Being Released:

X-ray/US ☐

Test Results ☐

Medical Notes ☐

Authorisation for Release of Patient Information Name:

I _____ hereby request for my records, as detailed above, to be released to myself (delete if not applicable) OR with my consent to:

Name: _____

Address: _____

_____

I enclose a copy of my passport/driver's license as proof of identity* ☐

I enclose a fee of €_____ (if applicable) ☐

I authorize the release of my medical records as indicated above.

Signed: _____ **Date:** _____

*Note: ID should also be provided by your nominated representative

Understanding My Rights as a Patient

1. I understand the release of the records will no longer preserve the confidentiality of my records and the information contained therein.

2. I understand that this authorisation is voluntary. Treatment, payment enrolment or eligibility for benefits may not be conditioned on my signing this authorisation except if the authorisation is for:

- Conducting research-related treatment
- To obtain information in connection with eligibility or enrolment in a health plan
- To determine an entity's obligation to pay a claim
- To create health information to provide to a third party

3. I understand that I may revoke or alter this authorisation at any time, that I do so in writing and submit it to Castlepollard Medical Practice. However, I understand if I revoke this authorisation, it will not have any effect on actions Castlepollard Medical Practice took before they received my revocation.

4. Once this health information is disclosed, how the recipient further discloses may no longer be protected under data protection legislation or by Castlepollard Medical Practice

5. I understand that I am entitled to request and receive a copy of this authorisation.

Proof of Patient Authentication:

Photo ID ☐

Signed Consent ☐

Spoke to Patient Directly ☐

Signature of staff member who carried out patient authentication:

Name: _____