Tasmanian Government Department of Health

CONSENT TO SHARE PERSONAL INFORMATION

Request for Health Information / Records.

OFFICE USE ONLY:

Patient Identifer:

Patient/Client Details	
Last Name:	First Name:
Previous Name/s:	
Date of Birth:	

Day Time Contact Details	
Contact Number:	
Email:	
Current Address:	
State:	Postcode:
Previous Address:	
State:	Postcode:

Who do you authorise us to share your personal information with?

Full name of person OR name of Business Unit OR name of Government Agency etc

Note: If the person you are authorising the sharing of your person information with is picking up the information on your behalf, they must produce photo identification before the information will be released.

Name:	
Address:	
State:	Postcode:
Contact Number:	

I hereby certify that the details provided on this form are true and correct and made free of undue influence. I consent to a check of records of the Department of Health and to release this information to the nominated person(s).

Name:	
Signature:	Date:

Please note: By signing this consent form you are agreeing to the disclosure of your personal information to the nominated person(s). Personal information will be managed in accordance with the *Personal Information Protection Act 2004*

Privacy Statement

The Department of Health collects personal information provided in this form for the purposes of assessing your request for personal information. Personal information will be managed in accordance with the *Personal Information Protection Act 2004* and may be accessed by the individual to whom it relates on request to the Department.

Office Use Only:	
Date Received:	**Proof of identity sighted:** ☐ Yes ☐ No

Reset