**Clinic Release of Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorise Wellnation Clinics, a division of Australian College of Natural Medicine Pty Ltd, to use and disclose the protected health information described below to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Full name of individual seeking the information)

This authorisation for release of information covers the period of health care from:

1. [x]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (dd/mm/yyyy) (dd/mm/yyyy)

**Or**

1. [ ] All past, present, and future periods.

**In addition**,

* 1. [x]  I authorise the release of my complete health record, or a summary thereof (including records and/or referral letters relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**Or**

1. [ ]  I authorise the release of my complete health record (or summary thereof) with the **exception** of the following information:

[ ]  Mental health records

[ ]  Communicable diseases (including HIV and AIDS)

[ ]  Alcohol/drug abuse treatment

[ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

1. This medical information may be used by the person I authorise to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. This authorisation shall be in force and effect until \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_(date), at which time this authorisation expires.
3. I have the right to revoke this authorisation, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorisation or if my authorisation was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. That information used or disclosed pursuant to this authorisation may be disclosed by the recipient and may no longer be protected by federal or state law.
5. I will be required to provide photo ID before any health records (or summary) will be released.
6. The information is released in compliance with the Australian Government privacy rights https://www.oaic.gov.au/

**Signature of client or personal representative: Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed full name of client or personal representative. His / Her relationship to patient.**

ID sighted and approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_