



AUTHORITY TO RELEASE MEDICAL RECORDS

Authorisation to transfer the **complete medical record** to Vive Women's & Family Health.

HOW TO COMPLETE THIS FORM

1. Download and save this form.
2. Complete all fields on screen.
3. Patients over 16 years must each sign the 'Patient Consent' on page 2.
4. Where legally authorised, a parent/guardian may request medical record transfer on behalf of a child under 16 years.
5. Sign and return the form in one of two ways:
 - Either:** Print your filled-in form, physically sign, scan and return via email to **support@vive.net.au**
 - Or:** Create and save your signature(s) on your computer, e-sign, and save the signed form as a PDF, then return via email to **support@vive.net.au**

PATIENT DETAILS

Full name(s)

Date of birth

Address:

Phone:

Email:

RECORDS TO BE REQUESTED FROM

Doctor / clinic name:

Address:

Phone:

Email / fax:

PATIENT AUTHORITY

I authorise the doctor / medical practice named above to release to Vive Women's & Family Health, the complete medical records of the individuals listed on this form.

Please send the records securely in **XML format** to: **support@vive.net.au**

Continue to page 2 for consent and signatures →

This form contains personal health information. Please handle and return it securely.



CONSENT AND SIGNATURES

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PATIENT CONSENT (REQUIRED FOR INDIVIDUALS OVER 16)

I understand that this consent is for the transfer of my complete medical record to Vive Women's & Family Health for continuity of care. By signing below, I authorise this transfer.

Each patient over 16 years must print their name and sign beside it.

	Full name(s) (Print)	Signature	Date
1.		X	
2.		X	
3.		X	
4.		X	

PARENT / GUARDIAN AUTHORITY FOR CHILDREN UNDER 16 / OTHER DEPENDANT

I confirm that I am the parent/guardian or am otherwise legally authorised to provide this authority on behalf of the child/children / other dependant listed in this form and I authorise transfer of their complete medical records to Vive Women's & Family Health. By signing below, I authorise these transfers.

Full name (print)	Signature	Date
	X	

Relationship to child/children / other dependant:

Return completed form to: support@vive.net.au

This form contains personal health information. Please send it only to the address above.