



Broome Regional Aboriginal Medical Service
(Aboriginal Corporation)

P.O BOX: 1879 BROOME, WA 6725 PHONE: 9192 1338 FAX: 91921606

BRAMS and Member Services
Release of Information Request
Patient Consent Form

Dear Doctor / Clinic Manager,

Clinic address: (of Clinic that is holding patient information)

I,

Date of birth:

Address:

Consent for (Clinic Name) :

Address of Clinic :

as my Health Care Provider, to request and receive my below personal health information.

(Please tick)

- | | |
|--|----------------|
| <input type="checkbox"/> Full Health Summary | |
| <input type="checkbox"/> Specialist Letters | |
| <input type="checkbox"/> Medication List | |
| <input type="checkbox"/> Progress Notes | |
| <input type="checkbox"/> Discharge Summaries | |
| <input type="checkbox"/> Diagnosis | |
| <input type="checkbox"/> Pathology Results | Specify dates: |
| <input type="checkbox"/> ECG Reports | Specify dates: |

Please send the requested information under Strict Confidentiality
(Please tick and enter required information)

- ☐ Via MMEEx :
☐ Via fax :
☐ Via Post :

Signature of Patient

Date:

Witnessed By - (Please Print)

Date: