



# CONSENT FORM

## Medical records



<b>What is this form for?</b>	You can't access another person's medical record without their permission.
<b>Patient Living</b>	<ul style="list-style-type: none"><li>• The patient needs to agree that you can access their records by signing the authorisation below.</li><li>• This applies to ALL patients 16 years and older.</li><li>• If the patient can't authorise access for medical reasons, you might need to provide us with evidence that you're allowed to access their record.</li><li>• Some examples of evidence are:<ul style="list-style-type: none"><li>○ A Guardianship Order;</li><li>○ Family Court Parenting Orders;</li><li>○ Carer's card.</li></ul></li></ul> <p> You don't need to provide us with evidence if the child is under 16, and you are listed as their parent in the medical record, and there are no applicable Family Court Orders.</p>
<b>Patient Deceased</b>	<ul style="list-style-type: none"><li>• If the patient has passed away, you must provide us with evidence that you're allowed to access their records.</li><li>• You must provide a copy of:<ul style="list-style-type: none"><li>○ The death certificate; and</li><li>○ Proof of your right to access the records if you are not the patient's next of kin.</li></ul></li></ul>
<b>Who is the next of kin?</b>	<ul style="list-style-type: none"><li>• The next of kin is, in order:<ul style="list-style-type: none"><li>○ The patient's spouse or domestic partner immediately before their death;</li><li>○ An adult child of the patient (if there is no spouse or domestic partner);</li><li>○ A parent of the patient (if there is no spouse, domestic partner or adult child available);</li><li>○ An adult brother or sister of the patient (if none of the above are available).</li></ul></li></ul> <p> We may not be able to release the record to you if the record shows that the patient would not have wanted you to have access to it.</p>

### Authorisation:

I, \_\_\_\_\_ of \_\_\_\_\_  
(insert patient or next of kin name) (insert address)

hereby authorise Bendigo Health to release information about

\_\_\_\_\_ to \_\_\_\_\_  
(insert patient's name/ me) (insert applicant's name)

Signed \_\_\_\_\_ on date \_\_\_\_/\_\_\_\_/\_\_\_\_