CBHS Corporate Health Pty Ltd
ACN 85 609 980 896

Authorisation to Release Information

Member and Patient details

Please send this authorisation and accompanying information to:

By post:
CBHS Corporate Health Pty Ltd
Locked Bag 5098
Parramatta NSW 2124

Fax: 02 8604 3576

Member Care Centre: 1300 586 462

1. **Membership no.**

2. **Customer name** Mr ☐ Mrs ☐ Miss ☐ Ms ☐

   Surname

   Given names

3. **Patient's name**

   (If the patient is the same as the member write 'as above')

   Surname

   Given names

4. **Patient's address**

   State Postcode

5. Problem or reason for hospitalisation

Authorisation

6. I, patient/authorising person's names

authorise my doctor/s, hospital/s, or any other authorities concerned (as listed below) with my hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all relevant information to CBHS Corporate Health Pty Ltd and its Medical Consultant/s.

Medical Practitioner details

Referring General Practitioner ☐ Specialist ☐ Hospital ☐ Name

Address

State Postcode

Telephone ( )

Specialist ☐ Hospital ☐ Name

Address

State Postcode

Telephone ( )

Specialist ☐ Hospital ☐ Name

Address

State Postcode

Telephone ( )

Signature

7. If the patient is under the age of 18 years the member should sign.

Patient's signature

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