CBHS Health Fund Limited
ABN 87 087 648 717

Authorisation to Release Information

Member and Patient details

Please send this authorisation and accompanying information to:

By post:
CBHS Health Fund Limited
Locked Bag 5014
Parramatta NSW 2124

Fax: 02 9843 7677

Member Care: 1300 654 123

1. **CBHS membership no.**

2. **Member's name** Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other_____ ☐

   Surname

   Given names

3. **Patient's name**
   (If the patient is the same as the member write 'as above')

   Surname

   Given names

4. **Member'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 the CBHS Health Fund Limited and its Medical Consultant/s.

Medical Practitioner details

☐ **Referring general practitioner**

Name

Address

State Postcode

Telephone ( )

☐ **Specialist**

Name

Address

State Postcode

Telephone ( )

☐ **Hospital**

Name

Address

State Postcode

Telephone ( )

Signature

Patient/Member signature

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

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