FOI Application

Government of South Australia
SA Health

SA Ambulance Service

Patient Authority for the release of Medical and Personal Information

I, ____
(Name)

of, ____
(Address)

Date of Birth: ___ / ___ / _______

Hereby authorise SA Ambulance Service to release information to ________________________
(Name)

relating to the ambulance attendance I received on _____ / ____ / _________ .
(date of service)

Should I wish to revoke this authority, I will notify the SA Ambulance Service Freedom of Information Officer in writing.

Signature of patient ___________________________________

Name ___________________________________
(Print name)

Dated ___ /_____/______

Signature of witness* ___________________________________

Full Name ___________________________________
(Print Full Name)

Address of witness ___________________________________

____

____

Dated ___ /_____/______

***NB: The witness can be any person over the age of 18, other than the person being authorised to receive information.**