

# Optical Record Release Form



To preserve confidentiality of patient details, this form must be completed before records may be released.

## Patient Information

Name	
<input type="text"/>	
Address	DOB
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	Postcode
<input type="text"/>	<input type="text"/>

Release optical records for:

myself  additional family member (under 16 years of age)

Additional family members (under 16 years of age)

Name	DOB
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Release records to:

Myself  Optometrist/Optical dispenser/Ophthalmologist  
 Other please specify \_\_\_\_\_

Optometrist/Optical dispenser/Ophthalmologist (NOT a post office box)

Name	
<input type="text"/>	
Address	
<input type="text"/>	
<input type="text"/>	Postcode
<input type="text"/>	<input type="text"/>

**Patient Signature** (or the legal guardian for a child)

<input type="text"/>	Date
<input type="text"/>	<input type="text"/>

Teachers Federation Health Ltd | ABN 86 097 030 414  
A registered health benefits organisation

**Street Address:** 438 St Pauls Terrace, Fortitude Valley QLD 4006  
**Postal Address:** PO Box 265 Fortitude Valley QLD 4006  
**Toll Free:** 1300 360 701  
**Web:** www.tuh.com.au

TUH office use only  
Eyecare Manager Approval

<input type="text"/>	
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Processed by	Date Released
<input type="text"/>	<input type="text"/>

Sent by mail  Picked up in Person