# Authority to release information

I, [title and full name of practitioner here], am currently subject to conditions on my registration or undertakings accepted by the Health Ombudsman, and/or restrictions imposed on my provision of health services, which came into effect on [Choose date].

I am *(tick and complete applicable option/s)*:

a registered [insert registered profession] who holds registration with the [name of relevant Board] Board of Australia:

* Ahpra registration number [insert registration number]
* Medicare provider number [insert Medicare provider number]
* Private health insurance number [insert private health insurance number]

and/or

an unregistered [insert profession]

* Medicare provider number [insert Medicare provider number (if applicable)]
* Private health insurance number [insert private health insurance number]

I am affiliated with the following professional institutes/associations/accrediting bodies[[1]](#footnote-1):

| Institute/Association/Accrediting body\*\* | Membership/Client number |
| --- | --- |
| [insert Institute/Association/Accrediting body here] | [insert number here] |
| [insert Institute/Association/Accrediting body here] | [insert number here] |

For the purposes of monitoring my compliance with my conditions/restrictions/undertakings, I authorise the following entities to release information relating to my professional practice, prescribing or provision of a health service to the Office of the Health Ombudsman:

* the Department of Health, Queensland Government[[2]](#footnote-2)
* Services Australia[[3]](#footnote-3)
* private health insurers
* any other entity who may provide information relevant to my professional practice (including prescribing if relevant) or provision of a health service.

I further authorise the Office of the Health Ombudsman to release identifying information about me to the abovenamed entities to assist in the release of information.

## Practitioner’s signature

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: | [insert signature here] | Date: | [Choose date] |

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1. If you are affiliated with more than two associations, please provide details on a separate attachment [↑](#footnote-ref-1)
2. Only if applicable to the practitioner’s profession [↑](#footnote-ref-2)
3. Only if the practitioner has prescribing endorsements or a Medicare Provider Number [↑](#footnote-ref-3)