

# Authority for release of medical records

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## AUTHORITY

TO:

(NAME)  
(ADDRESS)

I, (CLIENT) born (DOB), of (ADDRESS) hereby authorise and request you to supply to Legal Aid Queensland such information as they may request relating to my medical, psychiatric, or psychological condition and treatment.

I further authorise the release of hospital or other clinical records required by any medical practitioner, psychiatrist or psychologist, who has been requested to prepare a report for Legal Aid Queensland.

I further authorise Legal Aid Queensland to supply to any person who has been engaged to prepare a report relating to my medical, psychiatric, or psychological condition and treatment, such information and documentation as they may deem necessary to assist in the preparation of such report.

DATED : .....

SIGNED : .....

WITNESSED : .....