

TRANSFER OF CARE FORM

Patient Details

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Consent for Release / Transfer of Information

I, _____ (*patient full name or Substitute Decision-Maker*)

hereby authorise the **release and/or transfer** of confidential medical records **as specified below**, and acknowledge that I understand the scope, purpose, and legal implications of this release.

Direction of Information Transfer

From (sending provider):

Clinic/Provider Name: _____

To (receiving provider):

Clinic/Provider Name: The Mind Cove

Address: PO BOX 913 New Farm QLD 4005

Phone: 1300 264 820 Fax: 07 07 3924 1326

Scope of Records to be Released (select all that apply)

- Entire file** – Includes all records, correspondence, clinical notes, assessments, reports, and administrative documents
- Assessments and formal reports only
- Session progress notes
- Correspondence (e.g. letters to third parties)
- Other (please specify): _____

Legal Acknowledgement and Authorisation

I acknowledge that:

- I understand the nature and content of the records being released and the possible implications of their disclosure.
- I have the right to access my records in accordance with the *Privacy Act 1988 (Cth)* and *Information Privacy Act 2009 (Qld)* legislation.
- I may withdraw this consent at any time, with written notice to the provider holding the records.
- The information released may no longer be protected by the disclosing provider once it is transferred to a third party.
- The receiving party is bound by their own privacy and confidentiality obligations, for which the disclosing provider is not liable after transfer.
- If I am not the client, I confirm I am legally authorised to make this request (e.g., as a guardian, attorney, or under relevant advance care directive).

Client / Substitute Decision-Maker Signature: _____

Full Name: _____

Relationship to Client (if applicable): _____

Date: _____