Request to release information

Surname			
Given name/s			
File number ***(if known)***		**DOB**	
Postal address			
Home phone		**Mobile**	
Email address			

Please note: **The information contained in the Order 43 medical may contain personal or sensitive information, and as such you should carefully review the content prior to releasing it to a third party for employment purposes.**

- I wish to request the release of a copy of my most recent CS Health ☐ External ☐ :

  Order 43 Preplacement medical ☐ Order 43 Periodic medical ☐ Chest x-ray ☐

  Other (please specify): _____

  Date of medical / x-ray (if known): _____

I understand that this request must be approved by the management of CS Health.

I understand that the company who requested the medical may also be notified of my request.

I understand that I am required to provide photo identification when submitting my request; if I am not submitting my request in person, my identification will require verification *(see page 2).*

I understand that the information requested will be released within 30 days of this request being received.

I wish to receive the above requested information by way of the following:

- Pick up in person at CS Health office ☐
- Via post to the above listed postal address ☐
- Via email to the above listed email address ☐

OR

- Please release the requested information to the following ***(for CS Health medicals only)***: ☐

Company / organisation name: _____

Contact name: _____

Email address: _____

Contact number: _____

Name			
Signature		**Date**	

If you are not submitting your request in person, your identification will require verification by one of the following:

- Chiropractor
- Dentist
- Justice of the Peace
- Legal Practitioner
- Medical Practitioner
- Nurse
- Optometrist
- Pharmacist
- Police officer
- Physiotherapist
- Psychologist
- Veterinary surgeon

Any person who is entitled to witness a Commonwealth of Australia Statutory Declaration as defined in the *Statutory Declaration Regulations 1993* is able to certify proof of identity documents. Please visit www.legislation.gov.au for more information.

Please note: you do not need to supply a copy of your identification to CS Health when submitting your request.

Identification verification (to be completed by the person verifying the identification)

I hereby confirm that I have sighted and verified the identification for the following person:

Name		**DOB**	
Identification verified *(licence, photo ID, other please state)*			

Verified by:

Name			
Title / Qualifications			
Address			
Contact number			
Signature		**Date**	

Office use only

Date received		**Regional office**	
Received by			
Identification	• Sighted by CS Health ☐ ID details *(type, expiry etc)*: _____ • Identification verification – Page 2 completed ☐		

Information release approval

Is this medical a preplacement?	Yes ☐ No ☐ ***If yes, ensure certificate is stamped appropriately***		
Approved	Yes ☐ No ☐	**Date**	
Company notification attended ***(Please state name of company representative and form of contact)***	Representative: Form of contact:	**Date**	
CS Health Manager name			
Signature			

Information released

CSO name		**Date**	
Signature			