

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 your medical/s 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.

Please complete the following

Is the requested information required for an upcoming external medical assessment/review appointment? Yes No

If yes, please provide date of appointment (if known): _____

What information would you like to request?	<input type="checkbox"/> Order 45 Health Assessment	<input type="checkbox"/> Order 45 Health Assessment Review
	<input type="checkbox"/> Health Assessment Medical Information	<input type="checkbox"/> Order 43 Preplacement medical (includes a detailed report)
	<input type="checkbox"/> Order 43 Periodic medical	<input type="checkbox"/> Site Access medical (includes a detailed report)
	<input type="checkbox"/> Chest x-ray report	<input type="checkbox"/> Functional Capacity Evaluation
	<input type="checkbox"/> HRCT report	<input type="checkbox"/> Other (specify): _____

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

How would you like to receive the information?	<input type="checkbox"/> Pick up in person at CS Health office
	<input type="checkbox"/> Via post to the above listed postal address
	<input type="checkbox"/> Via email to the above listed email address
	OR
	<input type="checkbox"/> Please release the requested information to the following: (This option is for medicals performed by CS Health only. Medicals performed by an external provider will only be released to the requesting client.)
	Company / organisation name: _____
	Contact name: _____
	Email address: _____
	Contact number: _____

- I understand that CS Health must validate and approve this request.
- I understand that I must 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 requested information will be released within 30 days of receiving this request.

Client Name		
Signature		Date

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

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

Any person who is entitled to witness a Commonwealth of Australia Statutory Declaration as defined in the *Statutory Declaration Regulations 2023* can certify proof of identity documents. Please visit www.legislation.gov.au for more information. You do not need to supply a copy of your identification document(s) to CS Health so long as an appropriate witness (as listed above) has sighted and verified your identification document(s) and has completed the ID verification section below.

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

I have sighted and verified the identification for the following person:

Name		DOB	
Identification verified <i>(Must be Photo ID e.g. licence, passport)</i>			

Verified by:

If this form is signed digitally, I confirm that the above signature is that of the client and the below signature is mine.

Name			
Title / Qualifications <i>(Please state your witness capacity from the above list)</i>			
Address			
Contact number			
Signature		Date	

To return completed form via email, please send to the following address: csh@coalservices.com.au

Office use only

Date received		Regional office	
Received by (print full name)			
Identification	<input type="checkbox"/> Sighted by CS Health ID details (type, expiry etc): _____ <input type="checkbox"/> Identification verification – Page 2 completed		

Validation of Information

Validated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date	
Comments / Notes				
Validated by				
Signature				

Information Checked and Released

CSO / ASO name		Date	
Signature			