SA Ambulance Service

Patient authority for the release of information

Customer Service Centre

I, _____ of, _____
(PLEASE PRINT FULL NAME) (PLEASE PRINT FULL ADDRESS)

_____

and date of birth: _____/_____/_____ hereby authorise SA Ambulance Service to release
(PLEASE PRINT DATE)

information to _____ relating to the ambulance
(PLEASE PRINT FULL NAME)

attendance I received on _____/_____/_____ . Should I wish to revoke this authority, I will
(PLEASE PRINT DATE)

notify SA Ambulance Service in writing.

……..

Signature of patient: _____ Date: _____/_____/_____
(PLEASE PRINT DATE)

Name: _____
(PLEASE PRINT FULL NAME)

……

Signature of witness: _____ Date: _____/_____/_____
(PLEASE PRINT DATE)

Witness name: _____
(PLEASE PRINT FULL NAME)

Address of witness: _____
(PLEASE PRINT FULL ADDRESS)

……

Please return completed form to:

Customer Service Centre
SA Ambulance Service
GPO Box 3
ADELAIDE SA 5001
Phone: 1300 13 62 72
FAX: (08) 8271 2619

SA Ambulance Service (SAAS) recognises the importance of protecting the privacy of individuals' personal information. To read our full privacy disclosure statement, please visit our website www.saambulance.com.au.