**Release of Information Request**

|  |  |
| --- | --- |
| **Your name** |  |
| **Contact telephones** |  |
| **Email**  |  |
| **Postal address (clinical notes will be couriered)** |  |
| **Name of Workplace/Employer/Institution** |  |
| **Name of Professional who provided service** |  |
| **Which Photo ID is attached?** | Drivers Licence | Passport |

**REQUEST FOR RELEASE OF INFORMATION**

We understand you would like access personal information regarding Vitae services which under the Privacy Act you have a right to obtain.

If requesting clinical notes you acknowledge and agree that a Vitae professional has been solely responsible for preparation of any clinical notes and any related reports and determines the content of such documents based on their own assessment of the information provided to them. You waive any right to object to the foregoing.

Vitae or the employer/institution retain all rights (including intellectual property rights) in the documents and all information created in preparing the documents.

In signing this form you are providing consent for Vitae to release the indicated information to you.

Please indicate what information you require

[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

**Dates of sessions**

[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

**Clinical notes**

I request that Vitae release the information that is associated with the services I have received from the above named Vitae professional.

Name of employee ………………………………………….…….

Signature of employee ………………………………………….…….

Date: …………………………..

**Please attached your Photo ID and email the completed form to:** glenda.schnell@vitae.co.nz

**Or post to**: The Privacy Officer,

 Vitae,

 PO Box 10950,

 Wellington 6143