Optical Record Release Form

To preserve confidentiality of patient details, this form must be completed before records may be released.

Member Information

TUH Membership Number

Name	DOB

Address

Postcode

Release optical records for:

☐ myself ☐ additional family member (under 16 years of age)

Additional family members (under 16 years of age)

Name	DOB

Release records to:

☐ Myself ☐ Optometrist/Optical dispenser/Ophthalmologist

☐ Other please specify _____

Optometrist/Optical dispenser/Ophthalmologist (NOT a post office box)

Name

Address

	Postcode

Member's Signature (or the legal guardian for a child) Date

TUH office use only

Eyecare Manager Approval

Processed by	Date Released

☐ Sent by mail ☐ Picked up in Person

Queensland Teachers' Union Health Fund Limited
ABN 38 085 150 376 A registered health benefits organisation

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