

SOLICITOR UNDERTAKING NOT TO DISCLOSE INFORMATION TO PATIENT (MRMHA-Q)

1a. Affix patient identification label in this box

Hospital:

UR No:

Surname:

Given Name:

Second Given Name:

D.O.B: Sex:

*Mental Health Act 2009 – Section 90
Chief Psychiatrist Standard – Patient and Solicitor Access to Patient Records
Government of South Australia – Information Sharing Guidelines (ISG)*

1b. PERSON ADDRESS DETAILS *(if not on or different from patient label above)*

Address:

Suburb/town: Postcode: _____

2. UNDERTAKING NOT TO DISCLOSE

I hereby agree not to disclose particular information to the above named person as it may affect their treatment and care, or the therapeutic relationship with the treating team, or put the person or others at risk.

The particular information has been fully described to me by the undersigned health professional.

I understand that the information I have agreed not to disclose will not be used as evidence by the treating team at a hearing.

3. SOLICITOR MAKING UNDERTAKING

Full Name <i>(Please print)</i> :	Designation: <i>(Please print)</i> :
Signature:	___ / ___ / 20 ___ at ___ : ___ (24-hour clock)
Firm/agency <i>(Please print)</i> :	

4. HEALTH PROFESSIONAL FACILITATING INFORMATION SHARING

Full Name <i>(Please print)</i> :	Designation: <i>(Please print)</i> :
Signature:	___ / ___ / 20 ___ at ___ : ___ (24-hour clock)
Health service/agency <i>(Please print)</i> :	

5. HEALTH SERVICE / AGENCY OBLIGATIONS

The solicitor must be given a copy of this form as soon as practicable.

The reasons for the making of this undertaking and the provision of copies must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

A COPY OF THIS DOCUMENT IS TO BE PROVIDED TO THE SOLICITOR AND THE ORIGINAL IS TO BE KEPT IN THE PATIENT'S MEDICAL RECORD.

Office of the Chief Psychiatrist	Inquiries: (08) 8226 1091	Act Forms Fax: (08) 8115 5551
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