BARWON HEALTH **INFORMATION SHARING REQUEST** **(HEALTH SERVICES IN BARWON REGION)**	UR: DOB: Surname: Given Name(s): Address: GP:

Provide a **summary** (Continued from page 4)

Do not release / send documents from the electronic health record.

Was any information withheld / not disclosed?
☐ Yes → select reason/s: ☐ Did not form a reasonable belief that the information requested is necessary for a family violence protection purpose ☐ Request contains excluded information ☐ Consent has not been provided ☐ There is not a reasonable belief of a serious threat to a person's life, health or safety
☐ No

If the information is about a child, did you seek the views of the child and/or family member?
☐ Yes → Date views sought: Who did you speak to? Provide summary of conversation:
☐ No → Provide reason(s) why:

Have you obtained consent from the victim/survivor, third party or children?
☐ Yes → Date consent obtained: Name/s: Verbal / written / implied consent details:
☐ No → Consent not obtained Provide reason(s) why:

Have you notified the victim/survivor, third party or child's parent/guardian this information has been shared?
☐ Yes → Date of notification: Name/s: Details: ☐ a child victim survivor (under 18 yrs) ☐ an adult victim survivor ☐ parent/guardian of a child victim survivor (under 18 yrs) ☐ an adult third party ☐ Other:
☐ No → Provide reason(s) why:

If there are any queries regarding information provided, please contact the relevant health service.