

CONSENT TO TRANSFER MEDICAL RECORDS

What this form is for

From 1 July 2026, the Visual Electrodiagnostic Service at Sydney Eye Hospital is operated by the Australian Ophthalmic Diagnostic Institute (AODI). Clinical records previously held by the Save Sight Institute, University of Sydney, need to transfer to AODI so that your care can continue without interruption.

This form applies to patients of all ages. If the patient is under 18, or an adult who requires a substitute decision-maker, a parent, guardian or authorised representative must complete the relevant section below.

1. PATIENT DETAILS

Family name			
Given name(s)		Preferred name	
Date of birth		Medicare number	
Address		Suburb / State / Postcode	
Phone		Email	

2. WHO IS COMPLETING THIS FORM?

Select one option and complete the relevant section below:

☐ The patient

I am the patient named above, and I am 18 years of age or older and able to make this decision for myself.

Complete Section 3.

☐ Parent or guardian

I am completing this form on behalf of a patient who is under 18 years of age.

Complete Sections 3 and 4.

☐ Authorised representative

I am completing this form on behalf of an adult patient who is unable to consent for themselves.

Complete Sections 3 and 5.

3. RECORDS TO BE TRANSFERRED

I consent to the transfer of the following records from the Save Sight Institute, University of Sydney, to the Australian Ophthalmic Diagnostic Institute (AODI):

- ☐ Clinical reports and diagnostic findings (ERG, VEP, EOG and other electrodiagnostic results)
- ☐ Clinical correspondence and letters to referring practitioners
- ☐ Appointment and treatment history
- ☐ Demographic and Medicare billing information
- ☐ Imaging held in connection with electrodiagnostic assessments (OCT, fundus photography, visual fields)
- ☐ Genetic and genomic reports where held in connection with this service
- ☐ All other clinical records held by the Save Sight Institute in connection with this service

Time period covered: All records from the commencement of my care in this service to 30 June 2026.

TRANSFERRING FROM

Save Sight Institute

University of Sydney
South Block, Sydney Eye Hospital
8 Macquarie Street, Sydney NSW 2000

TRANSFERRING TO

Australian Ophthalmic Diagnostic Institute (AODI)

Operated by Gordon Eye Surgery
South Block, Sydney Eye Hospital
8 Macquarie Street, Sydney NSW 2000

4. PARENT / GUARDIAN DETAILS — complete if patient is under 18

Full name of parent /
guardian

Relationship to
patient

Phone

Email

Relationship ☐ Mother ☐
Father ☐ Legal guardian ☐
Other:

Legal authority (if
not parent)

Declaration:

- ☐ I am the parent or legal guardian of the patient named above and I consent to the transfer of their medical records as described in Section 3.
- ☐ The patient has been informed of this consent in a manner appropriate to their age and understanding.

5. AUTHORISED REPRESENTATIVE DETAILS — complete if consenting on behalf of an adult

Full name of
representative

Relationship to
patient

Phone

Email

Basis for decision-making authority — select one:

- ☐ **Enduring Guardian** (Guardianship Act 1987 NSW) ☐ **Person responsible** under Guardianship Act s.33A
- ☐ NSW Civil & Administrative Tribunal (NCAT) Order ☐ Other — specify:

Document / order number (if
applicable)

Declaration:

- ☐ I am authorised to make health decisions on behalf of the patient named above and I consent to the transfer of their records as described in Section 3.
- ☐ I have provided a copy of the relevant authorisation document to AODI.

6. YOUR RIGHTS

You have the right to:

- Withdraw this consent at any time in writing
- Request access to records held by AODI
- Request correction of any inaccurate records
- Receive a copy of this completed form
- Ask questions before signing

You do not have to:

- Sign this form — consent is voluntary
 - Transfer all record categories (see Section 3)
 - Continue care with AODI if you do not wish to
- Records will remain with the University of Sydney if you do not consent. Discuss care options with your treating clinician.
- Questions?** Phone AODI: +61 2 9382 7300 · ipc.nsw.gov.au · 1800 472 679 (NSW IPC)

7. CONSENT DECLARATION

I confirm that:

- ☐ I am the patient, or I am authorised to complete this form on behalf of the patient (see Section 2)
- ☐ I have read and understood the information on this form
- ☐ **I consent to the transfer of records as described in Section 3**
- ☐ I understand I may withdraw this consent at any time in writing
- ☐ I have had the opportunity to ask questions and am satisfied with the answers provided

Patient signature

**Parent / guardian / representative
signature** (Sections 4 or 5)

Witness (optional)

Full name (print)

Full name (print)

Full name (print)

Date

Date

Date

FOR OFFICE USE ONLY

Date received	Received by	Consent type ☐ Patient ☐	Patient record updated
		Parent/guardian ☐	
		Representative	