

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

I hereby consent to the disclosure of my private medical information to:

Name: _____ Date of Birth: _____

Relationship: _____ Tel. No: _____

Address: _____

Please tick the statement/s applicable:

Full and open ended disclosure of any matter related to my medical record

Full disclosure of any matter related to my medical record for the period

(From) _____ (To) _____

Limited disclosure of the following aspects of my medical record:

- *Test Results*
- *Prescription queries*
- *Appointment queries*
- *Referral queries*
- *Any other matter related to my medical record, please state: _____*

I am aware that this consent may be revoked by me at any time.

Signature: _____ Date: _____

Witnessed by (not the individual for whom consent is being granted):

Name: _____ Signature: _____

Address: _____

If you need assistance in completing this form please ask the Receptionist.