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.