



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

Appointment queries

Prescription 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, in writing to the Practice Manager.

Signature: _____ Date: _____

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

Signature: _____ Date: _____

Address: _____

If you need assistance in completing this form please contact the Practice Manager.