PATIENT CONSENT TO RELEASE OF HEALTH INFORMATION

Patients details:

Forename …… Surname …….

Date of Birth ……..

Address……

Contact Number……..

I hereby give my consent for the release of:

☐ Online access only ☐ All health related information

☐ Appointments only ☐ Test results only

To the following person:

Forename …….. Surname …….

Date of Birth ……..

Address……

……..

Contact Number……

Relationship to Patient: Husband/Wife/Son/Daughter/Parent/Friend/Other ……..

(* The above person may be required to give proof of identity to the receptionist)

I wish this authorisation to continue:

☐ Until I turn 16yrs of age ☐ Until I turn 18yrs of age

☐ Until …… (please indicate date) ☐ Indefinitely

Signature of Patient ……..

Date completed ……..

For Practice Administration Staff:

Date passed to scanning ……

Added to patients record with level of access and end date …….