# 3rd PARTY CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

**Please Bring in FORM of ID – RECEPTION CHECKED ID ☐**

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 disclosure of any matter related to my medical record for the period (please enter dates below). Default will be a maximum of 12 month unless otherwise specified*

*(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**

**It is the Patient's responsibility to renew this consent following expiry on: …………………**

Signature: ________________________________Date: ___________

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

Signature: ________________________________Date: __________________________

Address: _________________________________________________________________

| GP USE only - Authorisation for 3rd Party consent period to be extended – Patients best interest or other reason state | Sign: | Date: |
| --- | --- | --- |
| Admin scan into patient record ☐ | Reminder added to front Screen ☐ | Code added on blue star ☐ |