Dr A W Curtis
Dr R Teare
Dr A Gately
Dr B White

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.

OR

☐ Full disclosure of any matter related to my medical record for the period:
(From) _____ (To) _____

OR

☐ Limited disclosure of the following aspects of my medical record:
- ☐ Test Results
- ☐ 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: _____

If you need help with this form, please ask the receptionist.