PATH HOUSE MEDICAL PRACTICE

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: _____

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