



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

Permission to access and manage my online ordering of repeat medication

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.