**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 circle the statement(s) that are applicable:

*Full and open ended disclosure of any matter related to my medical record* **YES / NO**

*Full disclosure of any matter related to my medical record for the period* **YES / NO**

( *From* ): ( *To* ):

*Limited disclosure of the following aspects of my medical record:*

* *Test Results* **YES / NO**
* *Prescription queries* **YES / NO**
* *Appointment queries* **YES / NO**
* *Referral queries* **YES / NO**
* *Any other matter related to my medical record, please state:*

 **YES / NO**

**I am aware that this consent may be revoked by me at any time.**

Signature: Date:

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

Name: Signature:

Address:

**If you need assistance in completing this form please ask the Receptionist.**