Date: .....

myallmedical PRACTICE

AUTHORISATION FOR 3RD PARTY DISCLOSURE

Due to documenting procedures for Accreditation and the National Privacy Principles we require you to complete this form: **AUTHORISATION FOR 3RD PARTY DISCLOSURE. Please print clearly, circle where appropriate and return to the surgery in the enclosed stamped addressed envelope supplied for your convenience.**

Patient Information:

Title:…… Given Name:..... Surname:.....

Date of Birth:.....

Telephone No. (Home) ..... (Work) .....

(Mobile) .....

Address:.....

.....

Postal (if different).....

Name of Next of Kin: ..... Relationship.....

Contact Telephone No.....

Mobile:……

I authorise for the Doctors and support staff of Myall Medical Practice to speak with either my next of kin, or

(Nominated Authorised Person): ....., in the event that I am unable to be contacted, or unable to contact the rooms myself, for the purpose of managing appointments, prescriptions, or collecting X-ray or Pathology results.

I acknowledge that confidential information about my medical condition will not be passed on to the nominated person without my express authority. I also agree to the release of information to other medical practitioners or institutions that may be treating me, now or in the future, but only to the extent necessary to treat the particular condition for which I have consulted the Doctors at Myall Medical Practice.

Patient Signature:..... Date:.....