HOLLYWOOD GYNAECOLOGY

Patient Authority to Release Medical Information to a Nominated Party:

PATIENT DETAILS

Surname/family name: ______________________ Given names: ________________________________

Date of Birth: ___ /___ /______

Address: ___________________________________Suburb: _____________________________________

Postcode: ___________ State: ___________

Name of specialist:

◯ Dr Robyn Leake ◯ Dr Jennifer Pontré ◯ Dr Krish Karthigasu

INFORMATION TO DISCLOSE

Please list the information you would like to be sent to the nominated person(s)

NOMINATED PERSON(S) DETAILS

Title: _____________ Surname: _____________________ First name: ___________________________

Name or Organisation: ____

Email: ___________________________ Phone: _______________________ Fax: ___________________

CONSENT

◯ I confirm that I am the person indicated in the 'Patient Information' section above and authorise the Practice to release the medical information indicated in the 'Information to Disclose' section, to the person(s) in the 'Nominated Person(s)' section.

Name: _________________________ Signature: ______________________ Date: ____ /____ /______