waikanaehealth

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO A THIRD PARTY

This form is not required for patients under the age of 16.

PERSONAL DETAILS

Surname: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Full given name: DOB:

Home Address:

Waikanae Health Chart Number (if known):

THIRD PARTY DETAILS

I give permission for Waikanae Health staff to share my medical information (as indicated below) with a third party named as follows:

Surname: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Full given name: DOB:

Home Address:

Daytime Phone Number: Afterhours Phone Number:

Relationship to me:

Are they a patient at Waikanae Health? ☐ Yes ☐ No

I give permission to share: (please tick to indicate preference)

- ☐ All my medical information, both current and historical
- ☐ All information dated from this day forward
- ☐ Test results only (Blood tests, Laboratory tests, Xrays and scans)
- ☐ Corespondence and results from Specialists
- ☐ Only the information as listed below:

AGREEMENT

Signed by patient: Date:

Name:

Signed by third party: Date:

Name: