GENERAL CONSENT FOR THE DISCLOSURE OF PERSONAL HEALTH/MEDICAL INFORMATION

This practice acknowledges our obligations to you under the Privacy Act 1988 (as amended). The personal information we collect from you will be used primarily to assist us in providing the highest level of medical care. We may liaise with your referring doctor and may be required to release test results to health care professionals or hospitals involved in your care. In some instances we may be required to release test results to your Fund to obtain approval for a procedure.

For further information on the management of your personal information, **our Privacy Policy is available on request.**

CONSENT

Please tick where willing to consent:

▫ I hereby give my permission for the doctors working in this practice to communicate with my referring doctor and any other health professional involved in my medical care. I understand that by doing so, information pertaining to my health may be released to health care professionals/hospitals that have an interest in my treatment and care currently, or in the future.

This authority does not cover legal reports or reports to insurance companies.

Signed: ____________________ **Print Name:** ___________________________

Witness:_______________________ **Date:** _____________________________