Clinical Information Consent Form

First Name: _____ **Family Name: _____**

D.O.B: _____ /_____ /_____ **Phone: _____**

Email: _____

Clinical Information Consent

It is the policy of EAHC Newton to only disclose your clinical information to yourself or another practitioner who may be involved in your treatment for a specific reason (eg. Specialists you have been referred to).

If you wish to authorise a **specific family member or contact person** to call on your behalf and discuss clinical information about you (including pathology and radiology test results) please specify below:

Name: _____

Relationship to you: _____

Authorised Phone Number: _____

Signed: _____ Date: _____ /_____ /_____

The above details will be recorded in your clinical file.

Please note: You have the right to revoke this authorisation at any time by submitting a written request signed by you to EAHC Newton.

The National Privacy Principles in the Privacy Act sets out how this Practice should collect, use, keep secure and disclose personal information. Please ask our reception team for a copy of our Privacy Policy or you can download it from our website.