PO Box 1034
Moe, Victoria 3825
Phone: 51279800
Fax: 51272022

Third Party Consent Form

_____

(Name of Patient)

Of: _____

(Address)

Hereby Authorise: _____

(Nominated 3rd party)

Of: _____

(3rd Parties Address)

To collect, use and disclose my personal information held by Central Gippsland Family Practice, including health information, for the purposes below;

- Check appointment details
- Pick up prescriptions on my behalf
- Obtain medical test results
- Speak to my Doctor/Nurse regarding my health

I understand that this form will be used by Central Gippsland Family Practice to manage and/or disclose the personal information that it holds about me.

I understand that I can withdraw this consent at any time through notification in writing to Central Gippsland Family Practice.

Patients Signature: Date:

_____ _____

Third Party Signature: Date:

_____ _____