Riverview Medical Centre's Consent to Disclosure of Medical Information Form

Patients Name .....

Address .....

.....

.....

Date of Birth .....

I am signing this form to allow the following person(s) to be given the access to my medical information about me:

Full Name .....

Relationship To Patient .....

Contact Number (s) .....

Full Name .....

Relationship To Patient .....

Contact Number (s) .....

The following may be discussed with the above person(s):
(Please ***TICK*** below where applicable)

- □ **Appointments**
- □ **Medication**
- □ **Results**
- □ **Treatment**
- □ **All of the above and all aspects of my care**

Consent to be given until withdrawn by me in writing.

Signed ..... Date .....