Charter Medical Private Hospital

CONSENT FORM FOR RELEASE OF PATIENT INFORMATION

PRIVATE & CONFIDENTIAL

Patient's Name: _____ DOB: _____

Mob Phone: _____ Landline: _____

Address: _____

_____

Date of Admission: _____ Procedure /Treatment: _____ (if different)

I _____ hereby give consent, for my records as detailed below,

X-ray / US MRI/CT ☐ ***Test Results*** ☐ ***Medical Notes*** ☐

to be released to myself (delete if not applicable) OR to:

Name: _____Indicate: **GP** or **Solicitor**

Address: _____

_____

I enclose a copy of my Driving Licence or Passport as proof of identity ☐

I authorise the release of my medical records as indicated above. I understand the release of the records will no longer preserve the confidentiality of my records and the information contained therein.

Signed: _____ Date: _____

Name in block Letters: _____

Signed on behalf of CMPH: _____ Date: _____

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