Goulburn Valley Health

Consent To The Release Of Information

FC:

VMO:
LMO:

Please ask the patient/guardian to complete the following:

Patient/Client Details:

Surname: _____ Given Name(s): _____

Previous Name (if applicable): _____ Date of Birth: _____

Address: _____

_____ Post Code: _____

I, _____ hereby consent to the release, of the
(Given Name) *(Surname)*

following information about myself/ _____
(Name of patient/client whom the parent or guardian is consenting for)

_____

_____

_____

_____

to the following health care service provider:

Name: _____

Organisation: _____

Phone: _____ Fax: _____

Signed: _____ Date: _____

Print name: _____

Relationship to patient/client: _____
(Designate the relationship to patient/client here .....eg. parent or guardian)

Original must be filed in the medical record

CONSENT TO THE RELEASE OF INFORMATION MR12N

Ref No: 306594
May-08