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Annex 1: Authorisation to release medical information

MARY BEGG AUTHORISATION TO RELEASE MEDICAL INFORMATION

NAME OF PATIENT: _____

MINE NO./FILE NO. _____

DATE OF BIRTH: _____

I, _____, give permission for the treating physicians to release medical findings and reports for treatment received, to Mary Begg Community Clinic referring medical doctors and FQM Healthcare.

I understand that I am giving permission to release medical information from treatment received that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, all Pathology / Radiology and medical findings by treating medical professionals, unless indicated in the following instruction:

_____

I understand that information disclosed under this authorisation might be re-disclosed by the recipient.

I understand that signing this authorisation is voluntary and my treatment will not be conditioned upon my authorisation of this disclosure:

I understand I have the right to revoke this authorisation at any time in writing.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

SIGNATURE OF PARENT / LEGAL GUARDIAN IN CASE OF MINOR OR LEGAL REPRESENTATIVE IF

PATIENT IS UNABLE TO SIGN: _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: PARENT / SPOUSE / NEXT OF KIN / LEGAL GUARDIAN *(please circle as applicable)*

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