Kaurna Country **194a Chandlers Hill Road, Happy Valley SA 5159**
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Authority to Disclose Information to a Third Party

By signing this form, you are providing your informed consent for a nominated third party to access your personal records held by our organisation. This authority is valid for a period of 12 months from the date of signing and must be renewed annually to remain in effect. Please note that you must be 16 years of age or older to sign this form, in accordance with the age of consent in South Australia.

You may revoke this consent at any time by providing written notice to our management team. Upon revocation, access by the nominated third party will be immediately withdrawn.

Patient Name: _____ **Date of Birth:** ___/___/_____

Address: _____ **Contact Number:** _____

_____

I hereby authorise and direct Chandlers Hill Surgery to release the following information in relation to my medical treatment/condition to the following person/s or institution.

Third Party Name: _____ **Third Party DOB (if Individual):** ___/___/_____

Relationship to Patient: _____ **PH No:** _____
(If applicable)

Information to Release: (Please tick)

☐ **Appointment Information**

☐ **Billing Information**

☐ **Results of Investigation Reports**

☐ **Clinical Information (including prescriptions)**

Patient Signature: _____

Date: ___/___/_____