PHONE 08 8522 2294
FAX 08 8522 5777

Shop 1, 75 Murray Street, GAWLER SA 5118

www.murraystreetmedical.com.au

(Only 16 and Older)
Authority to Release Information to a friend or family member on my behalf

This signed consent will authorise Murray Street Medical staff to provide medical information to the nominated person named below on your behalf.

I, ______________________________________ DOB: ___________________

Give permission for

____ DOB: ___________________
To receive the following information in person or over the phone on my behalf:

Appointments bookings / history	YES / NO
Medical Record	YES / NO
Clinical Results	YES / NO
ANY / ALL information from my medical records	YES / NO

I will advise Murray Street Medical in writing if the above request changes in any way and will not hold Murray Street Medical responsible for any of the above information being released to the above person/s in my absence.

Signed: ___________________ Date:______________________