North Coast Surgical Suite

Suite 14, Level 4
St Vincent's Specialist Medical Centre
20 Dalley Street
LISMORE NSW 2480

Dr Sally Butchers - 85 Tamar Street BALLINA NSW 2478

CONSENT FOR THE COLLECTION,
USE & RELEASE OF PERSONAL & MEDICAL DETAILS

I (patient), _____ Date of Birth: / /

Of (address) _____

_____ Phone: _____

Email: _____

(PLEASE CIRCLE 'YES' OR 'NO' BELOW)

Hereby give Dr R Simon / Dr S Butchers / Dr D Bills / Dr B Mupunga permission to obtain my medical details from, or supply information to, my GP/referring specialist/other healthcare and diagnostic providers involved in my ongoing care. **Yes**/**No**

I am aware that this practice stores its medical records electronically and that secure email systems are often used to allow efficient communication between this practice and other relevant medical practices. **Yes**/**No**

Where an encrypted messaging service is not available at the receiving end I give the practice permission to use standard email and fax. **Yes**/**No**

Consent for SMS appointment reminders **Yes**/**No** Mobile: _____

Next of Kin /Contact person: _____

Phone: _____Mobile:_____

Relationship to patient: _____

Consent to discuss: Appointments: **Yes** / **No** Results: **Yes** / **No**

Signature of Patient: _____ Date: / /

OR

Signature of Attorney/Guardian:_____ Date: / /