North Coast
Surgical Suite

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

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

To be signed only after reading the North Coast Surgical Suite "PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION" document.

I (patient), Date of Birth: / /

provide my consent for:

Dr Daniel Bills / Dr Sally Butchers / Dr Robert Simon / Dr Bliegh Mupunga / Dr Stephen Strahan

to collect, use and disclose my personal information as outlined in the **North Coast Surgical Suite "PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION"** document which I have read in its entirety.

This includes permission to access My Health Record: **YES/NO**

I understand that I may withdraw my consent as to the use and disclosure of my personal information (except when legal obligations must be met).

Signature of Patient: ________________________________ Date: ____/____/____

OR

Signature of Attorney/Guardian: ________________________________ Date: ____/____/____

FURTHER DETAILS :

ATSI Status: Aboriginal **Yes / No** Torres Strait Islander **Yes / No**

Address: ____

____

Mobile: ____

Home Phone:____

Consent for SMS appointment reminders **Yes/No**

Email: ____

Next of Kin /Contact person: ________________________________

Mobile: ________________________ Home Phone:________________________

Relationship to patient: ________________________________

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

Signature of patient:________________________________