Partners: Dr R Liddell MB ChB FRCGP DRCOG
Dr K Duthie MB ChB Dip Obs (NZ)
Dr P Guthrie MB ChB DRCOG
Dr S Henderson MB ChB MRCGP DRCOG
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CONFIDENTIAL PATIENT INFORMATION

CONSENT FORM TO ALLOW ANOTHER PERSON TO ASK FOR RESULTS/INFORMATION ON BEHALF OF A PATIENT

Patients Name:		(Print in Block Capitals)
Patients DOB:		

Patients Address:
(Please print in Block Capitals)

I hereby give consent that the person named below is allowed to ask for results and other information on my behalf:

Signature of Patient:

Name of Proposed Person:		(Print in Block Capitals)
Relationship to Patient:		(Print in Block Capitals)

Address of Proposed Person:
(Please Print in Block Capitals)

Signature of Proposed Person:

Dated:	

TO PATIENT – PLEASE FILL IN ALL THE DETAILS ABOVE AND RETURN TO RECEPTION AS SOON AS POSSIBLE SO THAT WE CAN ARRANGE FOR THIS.