**Sherbourne Road Medical Clinic.**

111 Sherbourne Road, Montmorency. VIC. 3094

Ph: 03 94351144, Fax: 03 94328687

**Consent Form – Medical Health Record Information**

Name: ………………………………………………………………............

Address: ……………………………………………………………............

DOB: / /

Pts Mobile Ph: ………………………….. Consent to receive SMS: Yes / No

*I hereby grant consent for the person/s listed below to be notified of all results of medical investigations (on my behalf) and to have unrestricted access to my personal medical information, until such time as said access is revoked by me in writing.*

*I understand that this may include access to sensitive medical information such as past medical history, pregnancy test results and STI results etc.*

Names of people I hereby give consent to:

Name: ……………………………………………………………. Relationship…………………………

Name: ……………………………………………………………. Relationship…………………………

Name: ……………………………………………………………. Relationship…………………………

Name: ……………………………………………………………. Relationship…………………………

Patient Signature: …………………………………….

Date: / /

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| Office Use Only : Recall in place for 18 y/o recall Yes / No |

I hereby revoke this consent

Patient Signature: ………………………………… Date: / /