**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** Entered into MD:* Progress Notes Yes / No
* Clinical action Yes / No
* Recall in place for 18 or 21st y/o recall Yes / No

Entered into Pracsoft Notes & Appointment Reminders Yes / No |

I hereby revoke this consent

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

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| --- |
| **Office Use Only** Consent removed from MD & Pracsoft once revoked by pt Yes / No |