TUGGERANONG SQUARE
MEDICAL PRACTICE

ABN 25077 457 532

CONSENT FORM

Patient
Name……………………………...........……………………………………….DOB……………..........……………

Address………………………………………………………………...

CONSENT FOR ACCESS TO INFORMATION

At some time your family may wish to discuss your treatment with us. Please indicate your consent to enable us to do this for the following family members:

Person(s) who may discuss my treatment:

Name	Contact Number	Address

CONSENT FORM FOR COLLECTION OF MY SCRIPTS/DOCUMENTS.

Should you require another party to collect scripts or documents from TSMP we require your permission in writing.

Person(s) who may collect scripts or documents on my behalf:

Name	Contact Number	Address

Please sign to confirm you agree to third party access to information as you have listed on this form. Should any circumstances change in relation to your consent for these matters, changes are required in writing.

Signed: .... Date: ……./……./…….
(Patient/Parent/Guardian)

Phone 02 6175 0400 | Fax 02 62932970
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