

## Patient Consent Form – Withdraw or Change Authority to Act (Third Party)

Dear Patient,

This form can be used if you wish to withdraw or change the authorisation for another person to act on your behalf when communicating with the staff of Hamilton Medical Centre (HMC) regarding your care.

I (Name) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ of  
(Address) \_\_\_\_\_ hereby

withdraw authority; or

change authority

for the following person(s), to act on my behalf, in the areas ticked or crossed below:

### Person 1

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Make/Change/Cancel Appointments

Receive results

Update contact details

Pick up prescriptions/referrals/requests/forms

Make or receive other calls, enquiries or correspondence, with any other HMC staff

### Person 2

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Make/Change/Cancel Appointments

Receive results

Update contact details

Pick up prescriptions/referrals/requests/forms

Make or receive other calls, enquiries or correspondence, with any other HMC staff

Please complete the form below if you understand and agree to the following statements in relation to the disclosure of your patient information.

## Consent to Withdraw or Change

I, \_\_\_\_\_, date of birth \_\_\_\_\_ have read the information above and understand that any previously submitted authority to act forms will be withdrawn or changed via this written instruction.

Patient name: (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PRACTICE USE ONLY:

Witnessed by (if applicable): (Staff signature) \_\_\_\_\_

Entered onto BP: (Staff Name) \_\_\_\_\_ Date: \_\_\_\_\_