Hamilton Medical Centre

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: _____

☐ 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: _____

☐ 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I, _____ have read the information above and understand that any previously submitted authority to act forms will be withdrawn or changed via this written instruction.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: _____