Springwood Family Medical
Shop 10, 49-51 Cheek Avenue
Gawler East SA 5118

TEL: (08) 8523 1880
FAX: (08) 8523 1885

(Only 16 and Older)
Authority to Release Information to a friend or family member on my behalf

This signed consent will authorise Springwood Family Medical staff to provide medical information to the nominated person named below on your behalf.

I, _____ DOB: _____

Give permission for

_____ DOB: _____
To receive the following information in person or over the phone on my behalf:

Appointments bookings / history	YES / NO
Medical Record	YES / NO
Clinical Results	YES / NO
ANY / ALL information from my medical records	YES / NO

I will advise Springwood Family Medical in writing if the above request changes in any way and will not hold Springwood Family Medical responsible for any of the above information being released to the above person/s in my absence.

Signed: _____ Date:_____