Consent to share clinical data with nominated 3rd party

Full Name:

Date of Birth:

Current address:

I do hereby consent for a doctor from Brownlow Health to release relevant information from my medical record; this information will normally be released verbally but may occasionally be in writing.

The named person whom I authorise release of this information to is:

Name:

Relationship:

This information is in regards to (please specify current or specific conditions for discussion):

Please add any additional Information (e.g. specify any time limitation or any conditions you specifically DO NOT want the doctor to share):

Signed …… Date ……..

If unable to obtain written consent, please indicate below to confirm verbal consent from the patient.

Verbal consent received from patient	Yes ☐	No ☐
Verbal consent coded (EMISNQVE10)	Yes ☐	No ☐
Patient alert setup to notify summary and time limit of consent	Yes ☐	No ☐