

Please complete this CONFIDENTIAL form to ensure accurate identification and information.

Privacy

The information requested below and relevant health information may be sent to other health professionals (eg. your anaesthetist) or organisations (eg. hospitals, pathology) where this is needed to provide your healthcare. As required by the Commonwealth Privacy Act 1988 we request your consent to send this information to these practitioners and organisations. Information will only be sent for the purpose of providing your healthcare.

You may request to review the information we have on file about you for the purposes of checking that the information is correct.

I consent to Dr Paul Belt sending my personal and health information to other persons or organisations where this is necessary to provide my healthcare.

SignedDate/...../.....

For more information about your privacy please ask to see your privacy information brochure or consult the Commonwealth Privacy Commissioner www.privacy.gov.au

Who is your regular GP? DR _____

The Address of the Clinic: _____

_____ p/code _____

Telephone (____) _____