

## **AUTHORITY FOR THIRD PARTY**

I, \_\_\_\_\_, of hereby authorise , Date of Birth:

Relationship to patient: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
(eg Mother/Father/Son/Daughter/Friend)

to

**(Please cross out items you do not wish to be made accessible)**

- Make changes and enquire about appointment times
- Collect prescriptions
- Collect referrals to treating specialists
- Collect pathology and x-ray request forms
- Obtain results of pathology/x-rays performed only on this date ...../...../.....
- Obtain results of any pathology performed past and present
- Discuss my medical condition/records past and present with my doctor
- Discuss information relating to my accounts on my behalf.

I acknowledge that it is my responsibility to notify the practice in writing should I wish to revoke this authority at any stage.

Signed:.....