EAST ADELAIDE HEALTHcare

# Results Consent Form

**Full Name: ____________________________________________D.O.B: ___________**

**Person Responsible for this Account (please circle)**

**Self**

**Parent/Guardian:** Name: ______________________________

Address: ______________________________

Medicare No. ______________________________

Contact No. ______________________________

**The National Privacy Principles in the Privacy Act sets out how this Practice should collect, use, keep secure and disclose personal information. (A copy of this is enclosed in your new patient folder)**

**Disclosure of Personal Information**

**Emergency Contact**

In case of emergency please list a family member or contact person to whom you authorise the doctor/practice to contact:

Name: ________________________________ Relationship to you: ____________

Contact No: ________________________________

**Pathology and Radiology Test Results**

It is the policy of East Adelaide Health Care to only disclose your test results to yourself or another practitioner who may be involved in your treatment for a specific reason (eg. Specialists you have been referred to).
If you wish to authorise a specific family member or contact person to call on your behalf and receive your results please specify below:

Name: ________________________________ Relationship to you: ____________

Signed: ________________________________ Date: ____________________

**The above details will be kept in your file. If for any reason you wish for the authorisations to change, you must advise the Practice in writing.**