Mansfield MEDICAL CLINIC

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Family and general medical practitioners teaching general practice

I (print name) …….

Of (print address) ……

Date of Birth: ……

Am the (state relationship) ……

of (name of child) ……

Child's Date of Birth: ……

HEREBY REQUEST AND CONSENT TO INFORMATION / TEST RESULTS WITHIN THE MEDICAL FILE OF THE ABOVENAMED CHILD TO BE RELEASED TO THE PERSONS LISTED BELOW

NAME……...

ADDRESS……

PHONE NO……...

FAX NO……

DETAILS OF ANY SPECIFIC INFORMATION REQUIRED (if applicable):

……

……

……...

FORMAT FOR INFORMATION TO BE PROVIDED (if applicable):

……

……

SIGNED …….. DATE: ……

OFFICE USE ONLY			
ID Sighted/Copied	Initials: Date:	**Actioned:**	Initials: Date: