South Eastern Sydney Local Health District

Facility: Adahps

CONSENT TO OBTAIN AND SHARE HEALTH INFORMATION – NEUROPSYCHOLOGY

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES020023

Client's Phone No. _____

Medicare Number _____ Single digit next to name _____

I give permission for Adahps to obtain and share information about my health as may be required from the following individuals and agencies:

_____

_____

_____

_____

_____

_____

_____

I have been given and understand the:

- NSW Health Privacy Leaflet for Patients ☐ Yes ☐ No
- Australian Charter of Healthcare Rights Information ☐ Yes ☐ No

This consent will be valid for two years from the date signed unless I withdraw it. I can withdraw consent at any time.

Print Name: _____

Signature: _____ Date: _____

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

NHSIS1212A 270723

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SES020.023