SMDCC
A PRIVATE
DAY ONLY HOSPITAL

SMDCC – Consent to Release Medical Information (AF2)

To whom it may concern:

I ____

(Insert name of person consenting release of information)

of ____

____

(Insert address details)

Date of Birth: _____ / _____ / _____

Hereby give permission for Southern Medical Day Care Centre and medical staff to:

Process any claims where possible via electronic claiming systems.

Have access to any results, information, tests and/or specimens' essential for the management of my medical condition.

Release my medical information to other health professionals exclusively for the ongoing management of my medical condition. This includes the medical specialist's forum called *'Multidisciplinary Team' (MDT)* meetings which occur at regular intervals.

Use the (de-identified) information in my medical file for the purposes of teaching, quality assurance reviews and for research purposes.

Signature: ______________________________

Date: _____ / _____ / _____