DR MATTHEW HOLLAND
B.Med (Hons); FRANZCOG

OBSTETRICAN, FERTILITY SPECIALIST AND GYNAECOLOGIST
Provider No: 256021FB ABN 93 582 460 399

AUTHORITY TO RELEASE INFORMATION CONSENT

ONE PER PATIENT

I, (name) .....

Of (suburb) ..... Born (date of birth) .....

To view our privacy policy please refer to www.drmatthewholland.com.au/privacy-policy

The Authority to Release Information Consent is to gain your consent for Dr Holland and his staff to release your information to the people you wish, for example family members, partners or friends. During the course of your treatment you may need to contact the Rooms to collect your test results or confirm medical information, without your consent we are unable to release this information to anyone but yourself. Written consent is required from any person 16 years and over. **Your GP and other medical doctors will automatically receive correspondence from Dr Holland and do not need to be added to this form.

AGREEMENT

☐ Yes ☐ No	INFO RELEASE. **Do you consent to any other person**, your spouse for example, to be able to request medical information on your behalf? **(If yes, please list below)**
☐ Yes ☐ No	SMS RESULTS. Do you consent to Dr Holland and staff to **sms the results of your medical tests** to your mobile number that has been provided by you?
☐ Yes ☐ No ☐ This does not apply to me	HEALTH FUND CHECK. Where applicable do you consent to Dr Holland and **staff to contact your health fund** to confirm that you are covered for treatment or delivery at Newcastle Private Hospital, where care in a hospital is required?
☐ Yes ☐ No ☐ This does not apply to me	MEDIA RELEASE. Pregnant ladies only: Do you consent to Dr Holland and staff to **share images provided by you on our social media** of you/your family/your child?

Please sign this document at your first appointment.

Signed ..... Date: .....

INFORMATION RELEASE

I give my consent to Dr Matthew Holland and staff to provide the medical information indicated to the person/s listed below:

Person one name: ..... DOB:.....

Contact number: ..... Relationship:.....

This person can ask for (please tick):

Appointment Information: Yes ☐ / No ☐ Medical Results : Yes ☐ / No ☐

Pregnancy results: Yes ☐ / No ☐ STI (sexually transmitted infections): Yes ☐ / No ☐

Person two name: ..... DOB:.....

Contact number: ..... Relationship:.....

This person can ask for (please tick):

Appointment Information: Yes ☐ / No ☐ Medical Results : Yes ☐ / No ☐

Pregnancy results: Yes ☐ / No ☐ STI (sexually transmitted infections): Yes ☐ / No ☐

PLEASE ALSO COMPLETE OUR PATIENT DETAILS FORM