Ministry of Health and Quality of Life

Consent for Disclosure of Health Information

Patient Data	Responsible Party or Legal Guardian Data
Surname	Surname .....
Other Names	Other Names .....
N.I.C Number	N.I.C Number .....
Hospital	Relationship to patient .....
Unit Number	Telephone No: .....

1. I, (a) the above-named patient (b) Responsible Party of the above-named patient (c) Legal Guardian of above-named patient* authorise the Ministry of Health and Quality of Life to disclose health information of the above-named patient consisting of:

   (a) *a Medical Report .....

   (b) *a Copy of his/her medical file .....

   (c) *Other medical documents as specified hereunder .....

   .....

   (The Unit Number/s of the Hospital record/s, Name of the hospital/s and start and end date of episode/s of treatment should be clearly indicated in the above-mentioned options)

2. * I also authorise the Ministry of Health and Quality of Life **not** to disclose the following information

   .....

3. * I further authorise the Ministry of Health and Quality of Life to submit the health information mentioned at paragraph 1 above to .....

   .....

I understand the purpose for disclosing the health information to the person/s noted above. I also understand that I can refuse to sign this consent form.

Name of witness .....

N.I.C Number .....

Signature .....

Date .....

..... Signature of Patient *or* Responsible Party *or* Legal Guardian*

Date .....

Thumbprint

** delete as appropriate*