

PATIENT CONFIDENTIALITY DISCLOSURE CONSENT FORM

I, the undersigned(full name)

As patient/Legal Guardian:

ID NO:..... hereby authorise(name of doctor)

Who is in possession of information concerning my medical diagnosis and treatment together with my health and person particulars to disclose such information to my Healthcare Funder and other Healthcare Providers.

I further wish to indicate that such permission to disclose such information is only for the purpose of treatment and management of my medical condition.

I further wish to indicate that this consent was given out of my own free will without any undue influence from(name of doctor)

This signed at on this day of20....

Signature of patient/Legal Guardian

Witness