Riverport Medical Practice

Third Party Consent Form

Patient's Full Name:_____

Date of Birth:_____

Address:_____

Telephone:_____

Enquirer/Complainant Name:_____

Relationship to Patient:_____

Address:_____

Telephone:_____

Please obtain the patient's signed consent below.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with, the person named above.

This authority is **for an indefinite period** / **for a limited period only*** (*delete as appropriate*)

*Where a limited period applies, this authority is valid until _____ (*insert date*)

Signed _____ (*Patient*) Date_____

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