**EAST CORRIMAL MEDICAL CENTRE**

A: 17-19 Murray Road, East Corrimal NSW 2518

P: 02 4284 4677 | F: 4283 1785

# **PATIENT PICK UP CONSENT FORM**

**INSTRUCTIONS**

Dear patient,

in the interest of maintaining your privacy – we now require a signed declaration to indicate your consent for a nominated representative to collect documents on your behalf. If you require someone to collect any documents for you, please fill out the declaration below. This must be handed into the practice upon or before collection and will be safely stored in your file.

**DECLARATION**

I hereby give consent for the below mentioned representative to collect the indicated document/s on my behalf.

|  |  |
| --- | --- |
| Document Type: |  |
|  |  |
| Patient Name: |  |
| Patient Signature: |  |
| Date: |  |
|  |  |
| Representative Name: |  |
| Representative Contact Number: |  |
| Representative DOB: |  |

**ADMINISTRATION USE**

* Photo Identification sighted prior to collection of stated documents
* Document scanned onto patient file