



BLACKBUTT

CLINICAL CENTRE

Level 1
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New Lambton NSW 2305
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Third Party Consent for Patients of Blackbutt Clinical Centre

I (Name): _____ Date of Birth: _____

Of (Address): _____

Hereby give permission for (Name): _____

From (Address): _____

Phone: _____ Date of Birth: _____

To act on my behalf for the following (please tick or cross relevant boxes below):

- Take calls
- Receive results
- Confirm, change and cancel appointments
- Access and request copies of my file
- Collect and request letters, request for pathology and forms etc.
- Make or receive any other enquiries or correspondence from any Doctor, Nurse or Administrative staff member at Blackbutt Clinical Centre.

If I choose to change this I will notify the surgery in writing and I understand that until I receive written confirmation from the surgery that these changes to third party consent will not be in effect.

Third Party Representative Signature: _____

Patient Name: _____ Date: _____

Signed: _____