BLACKBUTT
DOCTORS SURGERY
Quality healthcare made simple

BLACKBUTT DOCTORS SURGERY
Level 1
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New Lambton NSW 2305
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Third Party Consent for Patients of Blackbutt Doctors Surgery

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 Doctors Surgeriey.

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: ____