

Authorisation for Information

Authoriser – I hereby authorise:

First name + last name _____
Date of birth _____
Address _____

Authorised Person – The following person:

First name + last name _____
Date of birth _____
Address _____

The authorised person is to be granted information regarding my health condition and access to my medical records.

The treating doctors and practice staff are released from their duty of confidentiality towards the authorised person.

This written authorisation is valid until revoked by the authoriser.

Location, date

Signature of the authoriser

Authorised persons are required to identify themselves at any time upon request by means of a valid official identity document or, in the event of telephone contact, by verbal identification (providing address, date of birth, and details regarding the authoriser). The authoriser must also submit a copy of a valid official identity document together with this form.

- To be completed by the medical practice assistant (MPA): I hereby confirm the consistency of the personal details of the authoriser with the valid official identity document.

Name of MPA: _____ Date: _____