Authority Form

I, (name) ……….

Date of Birth: / /

Of Address ………

Suburb…………………………………………………………………………… Post Code ……………………………

Hereby Authorise the following people:

Person 1

Name ……………………………………………………………………………… Date of Birth / /

Relationship to patient ………………………………………………………………………………………

Phone Contact ………………………………………………………………………………………………………

Person 2

Name ……………………………………………………………………………… Date of Birth / /

Relationship to patient ………………………………………………………………………………………

Phone Contact ………………………………………………………………………………………………………

This authority includes the following for each person:

Please indicate below for **ALL** of the following:

Person 1	**Yes**	**No**	**Person 2**	**Yes**	**No**
To collect scripts			To collect scripts		
To be given my results on my behalf			To be given my results on my behalf		
To discuss/pay accounts on my behalf			To discuss/pay accounts on my behalf		
To make or cancel appointments on my behalf			To make or cancel appointments on my behalf		
To discuss my future care and treatment decisions and to agree to them on my behalf			To discuss my future care and treatment decisions and to agree to them on my behalf		

Signature………………………………………………………………………………… **Date** ……………………………………………

NB: There may be instances where results or appointments need to be discussed privately with the patient. This request will be at the doctor's discretion.