CRYSTAL PALACE
PHYSIO GROUP
Making People Better

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Consent to disclose confidential health information

Client Name: ____________________

Client Date of Birth: ____________________

Client Address: ____________________

Reference Number If provided in request: ____________________

I hereby consent to the release of my confidential health/medical information to the following parties:

Name: ____________________

Name of organisation if applicable: ____________________

Address: ____________________

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I understand the purpose for disclosing this personal health information to the organisation/person/s noted above. I understand that I can refuse to sign this consent form.

My Name (please print): ____________________

Signature: ____________________

Date: ____________________

Witness Name (please print): ____________________

Signature: ____________________

Date: ____________________