Kangaroo Island MEDICAL Clinic

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Authority to obtain Medical Records or Results

I, ... D.O.B .....
(Insert patient's full name & date of birth)

of .....
(Insert patient's address)

give authority for:

....., DOB:.....

to obtain medical records or results on my behalf.

I understand that this authority is ongoing, and if I wish to revoke this authority, I must notify the Kangaroo Island Medical Clinic in writing.

Signed: ..... (signature)

Print Name:.....

Date: ...../ ...../20 .....