

Campbell Medical Practice

5/32 Blamey Place
Campbell ACT 2612
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I, (name) _____ give permission for
my (relationship + name) _____ to
discuss my medical records, without myself being present, with Dr Kylie Scott.

Signed:

(Patient name)

Signed:

(Discusser's name)

Signed:

Dr. Kylie Scott

Signed:

Practice Manager
