Dokotela

Consent to Release Medical Information

I give consent for Dokotela to share my medical information with the engaged third party.

I understand that sharing my information may include, releasing copies of reports, releasing prescriptions, discussing my support needs, reviewing any incidents that have occurred with the people or providers within the engaged third party.

With my permission, Dokotela may also need to disclose information to other people when it is in my best interest. Dokotela may have to disclose some information without my permission if required by law.

Third Party Information:

Name of Third Party: _____

Third Party Email Address: _____

Duration of Consent: This consent is valid until withdrawn. I understand that I can withdraw my consent at any time by notifying Dokotela in writing.

Security and Privacy: I acknowledge that my medical information will be handled securely and in accordance with applicable privacy laws, including the Privacy Act 1988 and relevant state/territory laws.

Client Information:

Client's Full Name: _____ Client's Date of Birth:_____

Client's Home Address:_____

Client's Signature: _____

Date: _____

Contact Information: If you have any questions or wish to withdraw your consent, please contact us at.

Phone: 02 8003 7668

Email: enquiries@dokotela.com.au