



**Northern
Sydney
Vascular**

Northern Sydney Vascular

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Name: _____

Date of Birth: _____

CONSENT FORM

The Privacy Act prevents us from **obtaining information** regarding your medical history, previous medical records, test results, letters and other documents from hospitals and health practitioners **without your prior written consent**.

It also prevents us from **releasing** any information regarding your medical history, previous medical records, test results, letters and other documents to other medical practitioners or hospitals **without your prior written consent**.

If we do not have all your medical information, treatment and follow up may be very difficult.

Obtaining and/or releasing such information may often be required in order for Doctor to make an informed decision regarding your treatment and may also be required during the process of booking you in for tests or procedures.

By signing this form, you give Dr Neale and Dr Thoo the right to store, obtain and/or release information regarding your medical history, previous medical records, test results, letters and other documents to/from other medical practitioners or hospitals.

Signature: _____

Date: _____