Sight for Life Foundation

Sight for Life Foundation Ltd
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AUTHORITY TO RELEASE MEDICAL INFORMATION

I hereby consent to the release of medical information held by the Sight Foundation Theatre as set out below.

I authorise the release of my personal medical information to:	
Name	
Mailing address	
Email address	

I authorise the release of the following information to the party indicated above (clearly indicate one option):	
	Any or all information held about me.
	Specific information as set out below:

If no option is clearly indicated above, we will assume "any or all information" is to be provided.

Your details:	
Your name	
Address	
Email address	
Date of last procedure	
Signature and date	

This form is valid for three months from the date of signing. Undated forms will be considered invalid. If this form is completed under power of attorney, please attach a certified copy of the power of attorney (see "authorised witnesses": http://bit.ly/AUStatDec). Copies of up to ten pages of medical records are provided without charge, after which a charge of $2 per page will be applied to cover our costs of preparing and sending records.