

Consent to the disclosure of medical and personal information

I, _____,
(insert your name)

of _____
(insert your address)

State that:

1) I was born on _____;
(insert date of birth)

2) I appointed _____ my attorney(s)
(insert name of attorney or attorneys)

by way of an enduring power of attorney dated _____;
(insert date of enduring power of attorney)

3) I anticipate that it will be necessary for my attorney(s) to obtain proof of the state of my capacity to manage my legal and financial affairs because my attorney(s) has/have responsibilities to act for me when I lose capacity to manage those affairs;

4) I anticipate that I may attend a number of medical and other professional persons after making the enduring power of attorney and providing this consent, and I intend that such persons will be governed by this consent;

5) There are laws relating to privacy and confidentiality of my medical and personal information; and

6) This consent form remains in force until I revoke it or revoke the enduring power of attorney.

And I Consent

1) To the release of information to my attorney necessary to establish my state of capacity;

2) To the release by my attorney of this information to such persons and organisations as is necessary to give effect to my enduring power of attorney.

Signed by _____

Dated _____