Authorized Representative Form Medical

AUTHORIZED REPRESENTATIVE FORM MEDICAL

Complete all sections in full. Incomplete forms may delay processing.

Name: _____ **Date completed:** _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy **Record / MRN number:** _____

Address

Phone: _____ **Email:** _____

Emergency contact: _____ **Relationship and phone:** _____

ABOUT YOUR AUTHORIZED REPRESENTATIVE MEDICAL

Reason for completing this form

Have you completed this form before?

◯ Yes ◯ No ◯ Not sure

Relevant history

Current medication, supplements and allergies

PLEASE CONFIRM

- ☐ The information I have given is accurate and complete
- ☐ I will tell the practice if anything changes
- ☐ I have read and understood the privacy notice

FOR OFFICE USE ONLY

Received by: _____ **Date received:** _____ dd / mm / yyyy

Action taken: _____ **Reference number:** _____

Signature and date

Print name: _____