Genetic File Number____________

CONSENT TO RELEASE INFORMATION (GENERAL)

The intention of this form is to gather accurate medical information in order to determine whether there is an inherited condition in your family.

This form should be completed by the person who has been diagnosed with the condition, or their next of kin if deceased.

Full Name: ____

Address: ____

Telephone: Home: ______________________ Work: ______________________

Date of Birth: ______________________ Hospital Number: ______________________

If deceased date of death: ____

Date of Diagnosis	Medical Condition	Hospital Name / City

I hereby give permission for Genetic Heath Service NZ to have access to the medical records above.

NOTE: The information gained from these records may be specified in clinic letters and during clinic consultations. A summary of the findings may also be stored in hospital electronic databases.

I give consent for this information to be shared with overseas health professionals should this be requested by another family member. Yes ☐ No ☐

Signature: ______________________________ Date: ______________________

If you are signing this form for a deceased family member please complete below:

Name: ____

Address: ______________________________ Telephone: ____________

Your relationship to the deceased family member: ______________________________

Please return this form to:

____

Genetic Health Service NZ – Northern Hub
Auckland Hospital
Private Bag 92 024
Auckland Mail Centre
Auckland 1142
Tel: (09) 307 4949 Ext. 25870 / Toll Free: 0800 476 123 / Fax: (09) 307 4978