ROSEMONT ENDOSCOPY CENTRE

CONSENT TO RELEASE MEDICAL INFORMATION

TO WHOM IT MAY CONCERN

I (name)_____

of (address)_____

Date of Birth: _____

Hereby give permission for the Medical Practitioners attending the Rosemont Endoscopy Centre to have access to any results, information, tests and/or specimens essential for the management of my care.

I also give permission for the Medical Practitioners attending the Rosemont Endoscopy Centre to release any Medical Information to any Health Professional for the ongoing care and treatment of my health.

Signature: ✕ _____ **Date:** _____

I ***DECLINE*** to give consent to release medical information

Signature: ✕ _____ **Date:** _____