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| **CONSENT TO RELEASE MEDICAL INFORMATION** |
| * A member of your family has been referred to Genetic Services of WA to assess the risk of an inherited condition.
* To complete an assessment, we need to access medical records to confirm the types of and ages at diagnosis in your family. This can only be done with the permission of that person (or their next-of-kin if they are deceased).
* If you consent to this, please complete, sign, and return the consent form to us.
* **If you have access to medical reports, doctor’s letters and/or death certificates of family members who have had a diagnosis, a copy of this information would be helpful to us.**
* **All information will be treated in a confidential manner. Please contact us if you have any questions or concerns.**
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| **File Reference (URN):**  |
| **Surname:** | **Given names:** |
| Date of birth: | Maiden name: |
| Date of death (if applicable): | Place of death (if applicable): |
| GP Name & Address: |
| **Date of Diagnosis** | **Diagnosis** | **Hospital Name and Address** | **Name of Doctor** |
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| 🞎 | **I consent for GSWA to have access to my/my relative’s medical records.** |
| 🞎 | **I consent for GSWA to have access to stored tissue samples for testing if necessary.** |
| 🞎 | **I consent for GSWA to share this information with family members for the purpose of genetic counselling.** |
| Signature: | Date: |
| 🞎 Signed by self (person listed above) | 🞎 Signed by Next of Kin (if the person above is deceased)* *‘Next of kin’ is a person’s spouse or partner (the most appropriate).*
* *If there is no living spouse or partner, the next most appropriate person is a parent or child.*
* *If there is no living parent or child, the next most appropriate person is a brother or sister.*
* *If there is no living brother or sister, the next most appropriate person is a grandparent or grandchild.*
* *If no living grandparent/grandchild, the next most appropriate person is an aunt/uncle, nephew/niece.*
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| 🞎 Signed by Parent/Legal Guardian/Power of Attorney* *If the person above is under 18 years of age.*
* *If the person above is not legally capable of giving consent.*
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| Full name: |
| Address: |
| Telephone: (Home) (Mobile) (Work) |
| 🞎 I consent to be contacted by Genetic Services of Western Australia. |
| Please return this form by post, fax or email to the below address. |