Consent to disclosure of health information

I, _____, acknowledge that in order to make an informed decision about the disclosure of my clinically sensitive information:

- My health practitioner has discussed with me the reasons why information needs to be shared to assist with my ongoing care and treatment and;
- I have been given a copy of the '*Respecting your Privacy in Sexual Health Clinics'* brochure, and have had the opportunity to discuss this with my health practitioner.

I give my permission for the _____ Sexual Health Clinic/Service to share relevant health information about me with:

My general practitioner:

_____

(Insert name and location)

Other specialist service providers:

_____

(Insert name and location)

_____

(Insert name and location)

_____

(Insert name and location)

Other health services or clinics:

_____

(Insert name and location)

Signed: _____

Name: _____

Date: ____ / ____ / ____