Women CENTRE

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Menopause
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New Mothers

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Consent for Release of Medical Information

- PLEASE READ THIS FORM CAREFULLY – DO NOT SIGN IF YOU ARE UNCERTAIN OF, OR DO NOT AGREE WITH, THE TERMS OF CONSENT.
- IF YOU HAVE ANY QUERIES RELATING TO THIS FORM PLEASE CONTACT WOMEN CENTRE.
- FOLLOWING COMPLETION OF THIS FORM, PLEASE RETURN IT TO WOMEN CENTRE BY EMAIL, FAX OR POST.

1 : ABOUT

- YOUR RELATIVE HAS BEEN REFERRED TO WOMEN CENTRE FOR GENETIC COUNSELLING, DUE TO THE FAMILY HISTORY OF CANCER.
- TO PROVIDE AN ACCURATE RISK ASSESSMENT AND APPROPRIATE MANAGEMENT ADVICE, IT IS IMPORTANT THAT YOUR RELATIVE'S GENETIC COUNSELLOR OBTAINS ADDITIONAL INFORMATION ABOUT THE CANCER(S) OF AFFECTED FAMILY MEMBERS.

2 : FAMILY MEMBER OF INTEREST

THE GENETIC COUNSELLOR HAS REQUESTED REVIEW OF THE FOLLOWING FAMILY MEMBER'S CANCER-RELATED MEDICAL RECORDS:

- YOU____(INSERT NAME)
- OTHER FAMILY MEMBER____ (INSERT NAME)

YOUR RELATIONSHIP TO THE ABOVE-NAMED PERSON:

NEXT OF KIN (THE ABOVE-NAMED PERSON IS DECEASED)
PARENT/LEGAL GUARDIAN
POWER OF ATTORNEY

3 : FURTHER INFORMATION

- ONLY MEDICAL RECORDS RELATING TO CANCER WILL BE REVIEWED, AND INFORMATION WILL ONLY BE USED TO FACILITATE GENETIC COUNSELLING WITHIN YOUR FAMILY;
- IF YOU ARE AGREEABLE TO CANCER-RELATED MEDICAL RECORDS OF YOURSELF OR THE ABOVE-NAMED RELATIVE BEING ACCESSED FOR THIS PURPOSE, PLEASE COMPLETE THE INFORMATION BELOW AND RETURN THIS FORM AT YOUR EARLIEST CONVENIENCE;
- IF YOU HOLD ANY RELEVANT DOCUMENTATION (EG MEDICAL REPORTS, DOCTORS' LETTERS, DEATH CERTIFICATE) ABOUT CANCER THAT HAS OCCURRED IN YOUR FAMILY, IT WOULD BE HELPFUL IF YOU COULD ATTACH A COPY WHEN RETURNING THIS FORM.

4 : FAMILY MEMBER OF INTEREST'S DETAILS

TO THE BEST OF YOUR KNOWLEDGE, PLEASE COMPLETE THE FOLLOWING INFORMATION FOR YOURSELF OR THE ABOVE-NAMED RELATIVE:

FULL NAME ______________________________________ MR MRS MS MISS OTHER

FULL NAME AT TIME OF CANCER DIAGNOSIS (IF DIFFERENT TO THE ABOVE NAME) ______________________________

____

DOB ______ /______ /______ DOD (IF APPLICABLE) ______ /______ /______

ADDRESS ____

SUBURB ____________________ STATE ________________ COUNTRY ________________

TELEPHONE ________________________EMAIL ____________________________________

TYPE OF CANCER(S) ____

____

DATE OF DIAGNOSIS ______ /______ /______

MANAGING DOCTOR(S) – INCLUDING CONTACT DETAILS _______________________________

____

____

TYPE OF TREATMENT ____

____

____

5 : AGREEMENT

1. I CONSENT TO RELEVANT MEDICAL RECORDS RELATING TO THE CANCER(S) DETAILED ABOVE BEING ACCESSED FOR THE PURPOSE OF GENETIC COUNSELLING WITHIN MY FAMILY

   YES NO

2. I CONSENT TO STORED TUMOUR TISSUE SAMPLES BEING ACCESSED AND TESTED, IF RESULTS COULD FACILITATE GENETIC COUNSELLING WITHIN MY FAMILY

   YES – I WOULD LIKE TO BE INFORMED OF THE RESULTS AND THEIR IMPLICATIONS
   YES – I DO NOT WISH TO BE INFORMED OF THE RESULTS AND THEIR IMPLICATIONS NO

3. I AM SIGNING ON BEHALF OF

   MYSELF
   MY NEXT OF KIN, WHO IS DECEASED
   MY CHILD, WHO IS UNDER THE AGE OF 18 YEARS
   AN INDIVIDUAL FOR WHOM I AM EXERCISING MY POWER OF ATTORNEY

Sign______________________________Date ______/______/______