GENETIC HEALTH SERVICE
NEW ZEALAND
RATONGA HAUORA IRANGA
AOTEAROA

Family No: _____

Date: _____

GHSNZ hub: Auckland/Wellington/Christchurch
(delete as appropriate)

CONSENT TO RELEASE INFORMATION

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 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 the completed form to the genetics services that is looking after your whānau/family:

Genetic Health Service NZ
Northern Hub
Auckland City Hospital
Private Bag 92024
Auckland 1142
Ph: 0800 476 123

Genetic Health Service NZ
Central Hub
Wellington Hospital
Private Bag 7902
Wellington 6242
Ph: 0508 364 436

Genetic Health Service NZ
Southern Hub
Christchurch Hospital
Private Bag 4710
Christchurch 8140
Ph: 0508 364 436