DW Family Doctors

177 Pakuranga Road, Pakuranga, Auckland 2010
Ph（电话）: 09- 576 5177 Fax（传真）: 09- 576 5178

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION
(医疗信息授权书)

□ Test results(检查结果) □ Medical records(病历记录)

I(我)_____ (patient's full legal name 病人的全名), D.O.B.(生日): _____. NHI（医疗号码）: _____ hereby authorise DW Family Doctors to release my above information to (授权 DW Family Doctors 可以将我以上相关医疗信息告诉给) _____. ID number (证件号码) _____.

You have the right to revoke this authorization, in writing, at any time before it ends. (你有权在任何时候通过书面通知撤销此授权。)

_____ Patient's Signature (病人签名)

_____ Date of Signature (签名日期)