**HEALTH CARE COMPLAINTS COMMISSION**

## AUTHORITY FORM

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorise the Health Care Complaints Commission to access my personal health information and disclose this information to the person who made the complaint concerning my care and treatment.

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Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Commission use only**

File No:

Officer's Reference: