

CONSENT TO RELEASE INFORMATION – Living Individual

We have recently been asked to assess your family history of cancer. In order to do this, we need to confirm the diagnoses within the family. Please complete and return this form if you consent to us accessing your relevant medical records to learn more information about your diagnosis. This information will remain confidential and will only be used to aid in the assessment of your family history. Please feel free to contact us if you have any questions.

Our Reference number:

Family History Assessor assigned to your family (if known):

Full Name:

Date of Birth: NHI number: (if known)

Email:

Current Address:

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Telephone (Home): (Mobile):

General Practitioner:

GP Address:

Date of Diagnosis	Treated for (eg bowel cancer; polyps)	Hospital Name and City	Name of Specialist

I hereby give permission for NZ Familial Gastrointestinal Cancer Service to have access to my medical records.

Signature: Date:

Name (printed):

Please ensure that your family's Reference number and your contact telephone number (and/or email) is included on this form.

Once completed, please return your form via post, fax or email to the office that is managing your family's assessment*:

Upper North Island (& National Office)

**Post: NZ Familial GI Cancer Service,
Auckland City Hospital,
Private Bag 92-024,
AUCKLAND 1148**

Fax: (09) 375 4359

Email: NZFGCS@adhb.govt.nz

Lower North Island

**Post: NZ Familial GI Cancer Service,
Wellington Hospital,
Private Bag 7902,
WELLINGTON SOUTH 6242**

Fax: (04) 385 5441

Email: NZFGCR@ccdhb.org.nz

South Island

**Post: NZ Familial GI Cancer Service,
Christchurch Public Hospital,
Private Bag 4710,
CHRISTCHURCH 8140**

Fax: (03) 378 6569

Email: FBCR@cdhb.health.nz

***If you are unsure which office is managing your family's assessment, please return your form to the National Office based in Auckland.**