DR GIL KLEINER
M.B., B.S. (Syd), F.R.A.C.S.
EAR, NOSE & THROAT SPECIALIST
COSMETIC NASAL SURGEON
PROVIDER NO 319223 J

MR/MRS/MAST/MISS/MS

SURNAME:

FIRST NAME:

DATE OF BIRTH:

HOME ADDRESS:

HOME PHONE:
WORK PHONE:
MOBILE:

MEDICARE NUMBER: **Exp. date:**
PATIENT REF. NUMBER ON MEDICARE CARD:
PENSION NUMBER:
HEALTH CARE CARD NUMBER:
HEALTH FUND:

REFERRING DOCTOR:

PRIVACY CONSENT FORM

I hereby give my permission for my personal information and medical records to be used for:

1. Administrative purposes for the running of the practice.
2. Billing, either directly or through an insurer or compensation agency.
3. Use within the practice when necessary to pass on information to other treatment staff for ongoing care.
4. Disclosure of treatment and medical information to your referring doctor or other treatment providers.

Signed:.....

Date:.....

161 LIVINGSTONE ROAD
MARRICKVILLE NSW 2204
TEL: 9558-2466 FAX: 9558-4748

34 BURWOOD ROAD
BURWOOD NSW 2134
TEL: 9558-2466 FAX: 9558-4748

ALL CORRESPONDENCE TO: MARRICKVILLE SURGERY