Hawkins Clinic
GENERAL MEDICAL PRACTICE
30 Sturt Street Mount Gambier South Australia

Authority Form

I, Name:……

Date of Birth: / /

Of Address:……

Suburb:……Post Code:

Hereby authorize:

Name:……

Relationship to patient:……

Phone Contact:……

Name:……

Relationship to patient:……

Phone Contact:……

To collect prescriptions / results / accounts / appointments from Hawkins Medical Clinic on my behalf. (Delete if not applicable).

Signed:……

Name:……

Date: / /