CBHS
Health Cover for the CommBank Family

Please send this form and any additional information:
**By Post:** CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
**Fax:** 02 9843 7676 **Email:** pec@cbhs.com.au

# Authorisation to release information

## Member and patient details

1. CBHS details

Member no.

2. Member's details

Title Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr ◯

Surname

Given name

3. Patient's details
(If the patient is the same as the member write 'as above')

Surname

Given name

7. Member's address

Street number

Suburb/Town

State/Territory Postcode

5. Problem or reason for hospitilisation

## Authorisation

6. I, patient/authorising person's names

authorise my doctor/s, hospital/s, or any other authorities concerned (as listed below) with my hospitalisation, injury, disease or ailment, or the treatment or diagnosis, to supply all relevant information to the CBHS Health Fund Limited and its Medical Consultant/s.

Medical practitioner details

◯ Referring General Practitioner

Name

Address

State/Territory Postcode

Telephone ( )

◯ Specialist

Name

Address

State/Territory Postcode

Telephone ( )

◯ Hospital

Name

Address

State/Territory Postcode

Telephone ( )

7. If the patient is under the age of 18 years the member should sign.

Patient / Member Signature

✗

Date / /