MEDICAL PRACTITIONER CERTIFICATE
TREATING SPECIALIST

AIA Health

Consent by patient for release of information

The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of my medical information relating to the condition(s) requiring hospital treatment to AIA Health Insurance. I also give consent for any other practitioner(s) who has/have seen me regarding the condition(s) to give medical information to the health fund.

Member name

Membership number

Address

Phone

Signature

Date of birth ☐☐/☐☐/☐☐☐☐

Date ☐☐/☐☐/☐☐☐☐

Certification by Treating specialist

Patient name

1. DATE of HOSPITAL admission (or proposed admission)

☐☐/☐☐/☐☐☐☐ to ☐☐/☐☐/☐☐☐☐

2. a. Principal condition

2. b. Nature of operation (if any)

2. c. Associated conditions (if any)

3. Date of patient's FIRST attendance for this illness

☐☐/☐☐/☐☐☐☐

4. Signs or symptoms of the condition (i.e. in 2a above) when first seen

a. consisted of

b. had commenced on ☐☐/☐☐/☐☐☐☐

c. had been present for ☐☐ days / ☐☐ weeks / ☐☐ months / ☐☐ years

5. Are you the specialist by whom the patient was treated? (please tick) ☐ YES ☐ NO

If YES – By whom was the patient referred to you? Referring practitioner

Date of referral

☐☐/☐☐/☐☐☐☐

Address of practitioner

Treating specialist's signature

Treating specialist

Phone

Address

Signature

Postcode ☐☐☐☐

Date ☐☐/☐☐/☐☐☐☐