CONSENT FORM

PASIFIKA INTEGRATED HEALTH CARE LTD
TEL 410-0251; FAX 410-9695

North Shore

PASIFIKA INTEGRATED FAMILY MEDICAL CENTRE LTD
TEL 410-0275; FAX 410-0282

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I, ____________________________ of ___________________________

Have consented/not consented (delete one) to participate in the cardiovascular disease self management program. I have given the GP and the nursing support team permission to access information required to assist with my care.

Signature: _________________________ **Date:** ____________

Name of GP/Nurse: ________________ **Signature:** ____________