Waiver of confidentiality

This waiver of confidentiality is signed by a patient who has the capacity to consent. If the waiver is for an incapacitated person or a person who does not have the capacity to consent, the guardian/next of kin must sign.

Patient's name (full name, use block capitals)

_____

Name of guardian/next of kin (if the patient is an incapacitated person or does not have the capacity to consent)

_____

releases the University Hospital of North Norway Health Trust (UNN) from the statutory duty of confidentiality in connection with the following examination/course of treatment at the hospital:

_____ _____

Contact info (mobile/email):

I authorise representatives of UNN to provide such confidential information to

Reporter_____

from (media) _____

I am aware that the waiver of confidentiality gives the University Hospital of North Norway Hospital Trust the ability to comment on my health and/or treatment, but that it does not imply a duty of disclosure to the media.

_____, on _____/_____ 20_____
(Place) (Date)

_____
Signature

This form is to be sent to the University Hospital of North Norway in one of the following three ways:

1) As a scanned attachment in an email to kommunikasjon@unn.no
2) By post: Kommunikasjonssenteret, Universitetssykehuset Nord-Norge HF, PO Box 100, 9038 Tromsø
3) Delivered personally by agreement

The completed form is kept and archived by the University Hospital of North Norway Hospital Trust.