



MEDICAL BENEVOLENT ASSOCIATION OF NSW

Doctors for Doctors since 1896

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PERMISSION TO RELEASE CONFIDENTIAL INFORMATION

Name _____

Address _____

I give permission for the Social Work team from the Medical Benevolent Association of NSW to contact

Name _____

Organisation _____

Regarding _____

I understand that this communication may disclose information about assistance I have received from the Medical Benevolent Association of NSW.

Name _____

Signed _____

Date _____