# Members Update Contact Details Form

Name: _____ / /

*First Name* *Surname* *Date of Birth*

Postal Address: _____

*Unit / Street No* *Street Name*

_____

*Suburb* *State* *Post Code*

Email Address: _____

Phone Number: _____

**I consent to receiving correspondence via**

*If this section is left blank, necessary correspondence will be sent via post.*

☐ **Email**

☐ **Mail (Australia Post)**

☐ **SMS**

By signing, I give my consent for this form to be used to update the Derbarl Yerrigan Health Service Aboriginal Corporation's Membership Register.

Signature: _____ Date: _____

☐ I would like this form to be used to update my medical records as well as my membership information.

**Please return this form to a Clinic Receptionist, or to the following details:**

*Company Secretary*
*1/111 Wellington Street*
*East Perth WA 6004*

*members@dyhs.org.au*

Accredited General Practice