

**Patient Consent Form**

**For another person to access their medical records**

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| **Patient Details** |  |
| **Surname** |  |
| **First Name** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Telephone number** |  |

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| **Details of person or persons with whom information can be shared with** |  |
| **Name** |  |  |  |
| **Relationship to patient** |  |  |  |

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| **Please detail below if the above access is to be limited in any way or omitted in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)** |
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| **I confirm that I give permission for the Practice to communicate with the person identified above with regards to my medical records.** |  |
| **Signature** |  |
| **Date** |  |