Patient Consent Form

For another person to access their medical records

Patient's Details

(The person whose records another individual(s) is to be given access to)

Surname:

First Names:

Date of Birth:

Male / Female:

Address:

Telephone No.

Details of person to be given access to this Patient's information

Full Name

Address

Relationship to Patient: (ie relative, friend, carer)

(if more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only.

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records

Signature

Date