**PATIENT CONSENT FORM**

The Practice is committed to maintaining Patient Confidentiality and will only discuss personal details and medical records with the patient. If you would like another individual to have access to this information please complete the consent form below.

|  |  |
| --- | --- |
|  **PATIENT DETAILS**  | **DETAILS OF NAMED INDIVIDUAL TO BE GIVEN ACCESS TO PATIENT’S RECORDS** |
| **Name**  | **Name**  |
| **Address**  | **Address**  |
| **Post Code**  | **Post Code**  |
| **Telephone**  | **Telephone**  |
| **E-Mail**  | **E-Mail**  |
| **Mobile**  | **Mobile**  |
| **Date of Birth**  | **Relationship to patient**  |

**I give permission for the above named individual to have access to my medical records and personal details held by the Practice and for staff to discuss this with them.**

**This permission relates to all of my medical records including but not limited to requesting medication, making appointments, referrals and receiving test results.**

**Signed........................................................................ (Patient)**

**Date............................................................................**