**PARK PARADE SURGERY**

**Patient Consent Form**

For another person/persons (eg son & daughter) to access your medical records

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| **Patient’s Details**  **(The person whose records another individual(s) is to be given access to)** | |
| Surname: |  |
| First Names: |  |
| DOB: |  |
| Male/Female: |  |
| Address: |  |
| Tel No: |  |

|  |  |
| --- | --- |
| **Details of person 1 to be given access to this Patient’s information** | |
| Full name: |  |
| Address: |  |
| Preferred contact number: |  |
| Relationship to patient: |  |

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| --- | --- |
| **Details of person 2 to be given access to this Patient’s information** | |
| Full name: |  |
| Address: |  |
| Preferred contact number: |  |
| Relationship to patient: |  |

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| **Please detail below if the above access is to be limited in any way (e.g. only for test results/passing on messages/making & cancelling appointments and/or if for a specified period only)** |
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| --- | --- |
| **I confirm that I give permission for the Practice to communicate with the person(s) named above in connection with my medical records** | |
| Signature: |  |
| Date: |  |