**PARK PARADE SURGERY**

**Patient Consent Form**

For another person 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: |  |

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

(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.)

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| **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 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 identified with regard to my medical records** |
| Signature: |  |
| Date: |  |