Patient Consent Form

For another person to access/ discuss their medical records

Patient's Details:

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

Title:	Mr / Mrs / Miss / Master / Ms / Dr/ Mx
First Name:	
Middle Name (if any):	
Last Name:	
Previous Surname:	
Date of Birth:	
Gender:	Male / Female
Address:	Postcode:
Home Number:	
Mobile Number:	
Email address:	

Details of the person to be given access to the Patient's information:

Title:	Mr / Mrs / Miss / Master / Ms / Dr/ Mx
First Name:	
Last Name:	
Relationship to Patient:	
Home Number:	
Mobile Number:	
Email address:	

An additional person to be given access to the Patient's information:

Title:	Mr / Mrs / Miss / Master / Ms / Dr/ Mx
First Name:	
Last Name:	
Home Number:	
Relationship to Patient:	
Mobile Number:	
Email address:	

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)

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Patient Declaration:

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

Print Name:	
Sign:	
Date:	

This document will be saved on your medical record.

The patient may ask for the consent to be removed at any time.

If you would like this letter or information in an alternative format (for example, large print or easy read), or if you need help communicating with us (for example, because you use British Sign Language), please let us know. You can call us on 0208 422 5602 or email haroccg.e84022@nhs.net