# Patient Consent Form

# for another person to access their 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** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Tel No.** |  |

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| **Details of person to be given access to this Patient’s information** | |
| **Full Name** |  |
| **Address** |  |
| **Telephone Number** |  |

(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, or for a specified time period only)** |
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| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.** | |
| Signature |  |
| Date |  |