**THE PARK SURGERY**

**Patient Consent Form – 16-18 year olds**

For another person to be allowed access to their medical records

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|  **Patient Details** |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Telephone Number |  |

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| **Details of Person/People to whom you give consent to access above patients information** |
| *Person Number 1* |
| Full Name |  |
| Address |  |
| Relationship to patient |  |
| *Person Number 2* |
| Full Name |  |
| Address |  |
| 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 or making/cancelling appointments) If no information is given below full access will be allowed** |
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| I understand that the consent given now shall last until my 18th birthday (unless I rescind it prior to this time) and that after that time, should I still wish to provide consent, another form shall need completing |
| **I confirm that I give permission for the practice to communicate with the person/people identified above in relation to my medical records.** |
| Full Name |  |
| Signature |  |