**THE PARK SURGERY**

**Patient Consent Form – Over 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 |  |

|  |  |
| --- | --- |
| **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 or for a specific time period only) If no information is given below full access will be allowed** |
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| --- | --- |
| **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 |  |