Manor House Surgery
Consent to share information

Please read carefully and complete all relevant parts

Patient Details			Relative/Carer	
Name			Name	
Address			Address	
Post code			Post code	
Date of Birth			Date of Birth	
Telephone/Mobile number			Telephone/Mobile number	
			Relationship to patient	

Patient

I give permission for my ***relative/carer/.....***to have access to my medical records and personal medical information held by the Practice and for the Practice staff to discuss this information with my ***relative/carer/.....***

This permission relates to ***all/part*** of my medical record. (Delete as appropriate)
Where permission is restricted to part of the record only the areas included are:

Specific exclusions are:

I understand that this consent will remain in force indefinitely and will be reviewed annually. However, I understand I have the right to withdraw consent at any time by informing the Practice of my decision.

Patient Signed..... Date.....

Relative /Carer/.....

I will treat any information provided to me confidentially, I will not disclose information to a third party without agreement. I understand consent can be withdrawn at any time.

Signed ..... Date.....

Practice Use Only
Emis Number.....
Alert & Rev DateAdded
Code 9NdG added