Consent to Share Information

Patient Details:

Name……Date of Birth……..……

Address……..

…….……..

Telephone……Mobile……

Representative (Relative/Friend/Carer) Details:

Name……..…Date of Birth…….…..……

Address……..

…….……..

Telephone……Mobile……

I give permission for my representative named above, to have access to my medical records and personal details held by the practice and for staff to discuss these with my representative.

Signed……(Patient)

Date……..

Any information I receive will be treated in the strictest confidence.

Signed……(Representative)

Date……..

Consent given to share patient data with specified 3rd party XaNwR