CONSENT FOR 3rd PARTY TO DISCUSS MEDICAL INFORMATION

(OPTIONAL)

If you have a ‘Health and Welfare’ Power of Attorney, please bring in your original so that we can record this on our records. (You do not need to fill in this form, if you possess the above Power of Attorney.)

I ……………………………………………………………………………………………………………………………….(Full Name)

Date of Birth …………………………

Address ……………………………………………………………………………………………………………………………………….

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Postcode ……………………………………….

I give my permission for my carer named overleaf to have access to my medical records and personal details which are held by the practice.

This permission relates to the following:

**ALL OF MY RECORD Yes/No**

**PART OF MY RECORD Please specify**

**SPECIFIC CONDITION Please specify**

I give permission for a clinical member of staff to discuss my medical condition(s) with my carer named overleaf. **Yes/No**

I give my permission for my carer to access test results on my behalf. **Yes/No**

**Carer Details**

Name ………………………………………………………………………………………………………………………………………..

Address ……………………………………………………………………………………………………………….......................

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Postcode …………………………………………………..

Telephone contact number(s) ……………………………………………………………………………………………………

Email ………………………………………………………………………………………….

**Confirmation of consent**

**Patient Signature** ………………………………………………………………….

Date ……………………………………………..

***Signature witnessed by independent person***

Name (please print) ……………………………………………………………………….

Signature ………………………………………………………………………………………

Date …………………………………………