concord
MEDICAL CENTRE

Patient Consent Form
Giving Permission to Allow another Person Access to their Medical Records

Patient Details (The person whose records another individual(s) is to be given access to)			
Surname:		First Names:	
Date of Birth:		Male/Female:	
Address:			
Tel No:		Mobile No:	

Details of Person to be given Access to this Patient's Information			
Surname:		First Names:	
Date of Birth:		Male/Female:	
Address:			
Tel No:		Mobile No:	
Relationship to Patient:		Are you their carer? Yes ☐ No ☐	
Are you a Patient of the Practice? Yes ☐ No ☐			

If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper and signed each sheet of paper.

Please give details below if the above access is to be limited in any way (e.g. only for test results, only for making and cancelling appointments or for a specified time period only)

I confirm that I give permission for the Practice to communicate with the person(s) identified above in regards to my medical records
Signature
Date:

If the named patient does not have the mental capacity to manage their own affairs and you have a Lasting Power of Attorney please tick here ☐ and provide a copy of the legal documentation as evidence.