Old School Surgery
Consent to Access Medical Information

Patient Details

Name: ______________________ Date of Birth _______________

Address: ____

____

Telephone number _______________

All your medical & personal information is strictly confidential. Within the Data Protection Act and Access to Health Records we require your consent to release any information to your Carer or next of kin. We would be grateful if you could complete the section below if you are happy for us to discuss your medial needs with a named person.

Consent

I give permission for (insert Carer's name) ____________________ to contact the surgery on my behalf to:

(Please indicate yes or no to each area)

Order & discuss my medication.	Yes / No
Obtain test results on my behalf.	Yes / No
Make and receive information relating to my appointments.	Yes / No
Discuss or received information relevant to my medical needs.	Yes / No

Other, please specify:____

I am aware that I can reverse this decision in writing at any time.

Signed (by Patient) ___________________________________

Date: ____________________

FOR COMPLETION BY THE CARER

I give permission for Old School Surgery to store my name and telephone number on the above patient's records in order for the surgery to contact me to discuss the above patient.

SIGNED (BY CARER) ____

TELEPHONE NUMBER OF CARER ___________________________________