THEALE MEDICAL CENTRE

Patient Consent Form
for another person to access their medical records

Patient's 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.	

Details of person to be given access to this Patient's information	
Full Name	
Address	
Relationship to patient	
Date of Birth	
Mobile 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)

Please tick below the access to be given if you wish it limiting (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)
If you do not tick or comment in this box full access will be assumed.

Prognosis	☐	Urine	☐	Discussion with GP	☐
X-rays	☐	Pregnancy	☐	Make appointments	☐
Biopsies	☐	Ultrasound	☐	Cancel appointments	☐

MRI Scan	☐	CT Scan	☐	Hospital appointments	☐
Bloods	☐	Repeat Meds	☐		

Comments:

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