**Howard Medical Practice**

Patient Consent Form

For another person to be given access to medical records & information

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| **Patient Details**  (the person whose records another individual is to be given access to) | |
| **Surname** |  |
| **First Name/s** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Address** |  |
| **Tel No.** | **Home:**  **Mobile:** |

|  |  |
| --- | --- |
| **Details of person to be given access** | |
| **Full Name** |  |
| **Address** |  |
| **Tel No.** | **Home:**  **Mobile:** |
| **Relationship to patient** |  |

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| **Please detail below if the above access is to be limited in any way (eg. Test results only, making & cancelling appointments or for a specified time only. Please state clearly if full unlimited access is required** |
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| --- | --- |
| **I confirm that I give Permission for the practice to communicate with the person identified above in regards to my medical information & record** | |
| **Signature** |  |
| **Date** |  |

**\*\*\* Administration – code record 9NdG (snomed 319951000000105) and add patient ALERT**