Grantown on Spey Medical Practice

PATIENT CONSENT FORM FOR ANOTHER PERSON TO ACCESS THEIR MEDICAL RECORDS

Patient's Details (the person whose records another individual 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 information	
Full Name	
Address	
Date of Birth	
Relationship to Patient	

(if more than one person is to be given access then please list on a separate sheet of paper with the same details)

If the above access is to be limited in anyway e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only then please detail this below.

I confirm that I give permission for Grantown Medical Practice to communicate with the person identified above in regards to my medical records. I understand it is my responsibility to advise the Practice if I decide to withdraw this permission.	
Signature	
Date	