

**Consent Form for Patient Medical Record**

|  |  |
| --- | --- |
| **Patient Details** | |
| First Name |  |
| Surname |  |
| Date of Birth |  |
| Address |  |
| Tel. No |  |
| Mobile |  |
| Email |  |

|  |  |
| --- | --- |
| **Details of Person to be Given Access to this Patient’s Information** | |
| Full Name |  |
| Address |  |
| Tel No |  |
| Mobile |  |
| Email |  |

|  |  |  |
| --- | --- | --- |
| **I give permission for my person information held at the practice about me to be disclosed to the person stated above** | | |
| Discuss my medical record | Yes | No |
| View all of my medical history (This includes subject access requests, reports for insurance companies, consultations, test results, clinic letter) | Yes | No |
| Discuss and be given results (i.e. blood tests, swabs, urine etc) | Yes | No |
| Discuss my medical needs with clinicians and receptionists | Yes | No |
| Update my contact details if needed | Yes | No |

|  |  |
| --- | --- |
| Signature |  |
| Date |  |

I give permission for my person information held at the practice about me to be disclosed to the person stated above

**Practise Use Only**

**EMIS Codes:**

* Consent given to share patient data with specified third party
* Consent given to discuss preferred priorities for care with family member
* Consent given to discuss preferred priorities for care with carer