Patient consent form for another 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	
Address	
Tel No.	

Details of person to be given access to information 1		
Full Name		Relationship:
Address		
Tel No		

Details of person to be given access to information 2		
Full Name		Relationship:
Address		
Tel No		

(If more than this please list on a separate sheet of paper with the same details)

Please tick the box(s) below to indicate level of access:

Full medical access ☐

Appointments ☐

Prescriptions/ medication ☐

Results ☐

Referrals/correspondence ☐

Specified time only from: _____ to: _____

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