Consent to Share Information with a Carer/Relative/Nominated Person

|  |  |
| --- | --- |
| Patient  | Relative/Carer/Nominated Person |
| Name | Name |
| Date of Birth | Date of Birth |
| Address | Address |
| Postcode | Postcode |
| Telephone | Telephone |
|  |  |
| Mobile  | Mobile |
| Email | Email |
|  | Relationship to patient |

I give permission for my relative/carer/nominated person to have access to my medical records and personal details held by the Practice and for staff to discuss this with my relative/carer/nominated person.

This permission relates to all / part of my records. (Delete as appropriate)

Where permission is restricted to part of the records only, the areas included are:

Specific exclusions are:

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records at any time.

Signed.............................................................................. (Patient)

Date..................................................................................

Patients completing this form should be aware that they take responsibility for the use the nominated individual makes of any data shared with them.