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| Patient’s Details (the person whose information another individual is to be given access to) |
| **FULL NAME** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Telephone number** |  |

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| Details of person to be given access to information |
| **Full Name**  |  |
| **Address &** **Phone Number** |  |
| **Date of Birth** |  | **Relationship to Patient** |  |
| **Telephone number** |  |
| **SIGNATURE OF PERSON NAMED**  |  |

*(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.**

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| 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** |  |