GREAT OAKLEY MEDICAL CENTRE

PATIENT CONFIDENTIALITY – CONSENT FORM

Please complete this form if you would like to allow a specific person/people access to clinical information about you.

I hereby give my consent (please complete your details below)

Name …….. Date of Birth……..

Address ……

……

……

for (name of person/people to whom information may be given)

Name …… Relationship to patient …….

Address …… Telephone number……..

……

Name …… Relationship to patient …….

Address …… Telephone number……..

……

to be informed of all clinical information relating to me (please tick appropriate box);

Indefinitely ☐

Until (please add date) **……**

Date ……..

Signed (patient) ……

For surgery use only:

Scanned onto patient record …… (initials) Read coded …… (initials) Date ……