**SQUIRES LANE MEDICAL PRACTICE**

**Dr E Barthes-Wilson & Dr G Thawani**

# Patient Consent Form

# (For a person other than the patient to access their medical records)

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| **The details of the person whose records will be accessed**  |
| **Surname** |  |
| **First Names** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Tel No.** |  |

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| **Details of person to be given access to this information** |
| **Full Name**  |  |
| **Contact Details** |  |
| **Address** |  |
| **Relationship**  |  |

**(If more than one person is to be given access then their details should be listed on a separate sheet and attached to this form)**

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| **Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)**  |
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| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.**  |
| Signature |  |
| Date |  |