PRINCES GARDENS SURGERY

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Telephone : 01252 332210 Fax : 01252 312490

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

I hereby consent to the disclosure of my private medical information to:

Name: _____

Relationship: _____ Tel. No:_____

Address: _____

Please tick the statement/s applicable:

☐ *Full and open ended disclosure of any matter related to my medical record*

☐ *Full disclosure of any matter related to my medical record for the period from _____ to _____*

☐ *Limited disclosure of the following aspects of my medical record:*

- *Test Results* ☐
- *Prescription queries* ☐
- *Appointment queries* ☐
- *Referral queries* ☐
- *Any other matter related to my medical record, please state below:* ☐

_____

I AM AWARE THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME.

Signature: _____ Date: _____

Witnessed by (not the individual for whom consent is being granted):

Name: _____ Signature: _____

Address: _____

**** If you need assistance in completing this form please ask the Receptionist ****