Linden Medical Group

Carer - Patient Consent Form

Patient details:			
Surname		**Forename**	
Date of birth		**NHS number**	
Street		**Region**	
Town or city		**Postcode**	
Telephone		**GP details**	

Carer details:			
Surname		**Forename**	
Date of birth		**NHS number**	
Street		**Region**	
Town or city		**Postcode**	
Telephone		**GP details**	

I give permission for my named carer, to have access to my healthcare records held by my GP surgery. (Details below)

Please tick which option is applicable below:

This permission relates to all my records.	

The permission relates to part of my records.	
Please specify the parts of the record to which access is allowed and any areas which are specifically excluded.	

This permission relates to a specific condition.	
Please specify the condition.	

I understand that this permission will remain in force until cancelled by me in writing and that the doctor may override this authority at any time.
By signing below I consent to the above information being recorded on my medical record.

Signature (of patient)	
Date	

I agree that I will treat all information confidentially and will not disclose this information to any third party without the express permission of the person named as the patient above. I will only use this information in the best interests of the patient.

Signature (of carer)	
Date	

Please return completed form to reception.