Stickney Surgery

PATIENT CONSENT FORM
Sharing of information with Patient's nominated friend/relative

Part 1

Your written consent is required to allow the person name in Part 2 of this form to speak to the clinicians and staff at Stickney Surgery about your medical care.

Patient: _____ Date of birth: _____

I _____ (Patient's name) consent to the person named in Part 2 having access to information relating to my medical care at Stickney Surgery. This may include details of any diagnoses, treatments, care plans or anything else which may need to be discussed to enable Stickney Surgery to carry out my care.

Signature: _____Date: _____

Address: _____

_____

Telephone Number: _____

Your consent to share personal information is entirely voluntary and you may withdraw your consent at any time. It is your responsibility to inform Stickney Surgery of any change in circumstances regarding this form.
Should you have any questions about this process, or wish to withdraw your consent please contact the practice.

Part 2

Details of person to whom patient is giving consent to access their medical information:

Name: _____

Relationship to patient: _____

Address: _____

_____

Telephone Number: _____

Signature: _____

Date: _____