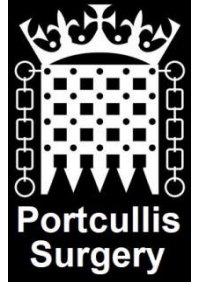


**THIRD PARTY ACCESS TO PATIENT CONFIDENTIAL MEDICAL RECORDS**

**(Patient consent for another to access their medical records and/or discuss their care with a medical professional on their behalf)**



**Patient's Details:**

Name: .....

Address: .....

Date of birth: .....

**Details of person/third party to be able to access the above patient's medical records and/or discuss their care with a medical professional on their behalf:**

**Person 1:**

Name: .....

Address: .....

Date of birth: .....

Telephone numbers: .....

Relationship: .....

**Person 2:**

Name: .....

Address: .....

Date of birth: .....

Telephone numbers: .....

Relationship: .....

**If more than two people are to be given this access please discuss with the practice.**

**Please detail below if the above access is to be limited in any way:**

No limits on access to medical records:

Only for test results:

Only for making/cancelling appointments:

Any other restriction: (describe below)

.....

.....

**I confirm that I give permission for the Practice to communicate with the person(s) identified above in regards to my medical records.**

**Signature:** ..... **Date:** .....

Please print off this form and return it to us by email or post.

Many thanks.

Portcullis Surgery, Ludlow. IX/MMXX.