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)

Portcullis Surgery

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)

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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.