BALLASALLA GROUP PRACTICE

Patient Consent Form
For another person to access their medical records

Patient Details	
Name	
Address	
Home Tel No.	
Mobile No.	
Email Address	
Date of Birth	

Relative / Carer Details	
Name	
Address	
Telephone No.	
Mobile No.	
Email Address	
Date of Birth	
Relationship to the patient	

If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper

I understand that my privacy will be protected at all times by the Practice and that the GP will use discretion with regard to the level of information to be given

I understand that this consent will remain in force indefinitely. If I wish to remove this consent at any time I will do so in writing to the Practice

Please detail below if the above access is to be limited in any way (e.g. Only for test results, or only for making & cancelling appointments, or for a specified time period only) PLEASE ADVISE IF ACCESS IS FOR ALL MEDICAL RECORDS

I confirm that I give permission for Ballasalla Group Practice to communicate with the person/s identified above in regards to my medical records	
Signature of patient:	Date:

I will treat any information provided confidentially. I will not disclose information to a third party without agreement and will only use the information in the best interests of the person I care for.

Signed _____ (carer/relative) Date _____