Uppingham Surgery
North Gate, Uppingham
Rutland, LE15 9EG
01572 823531

PATIENT CONFIDENTIALITY – CONSENT FORM

I hereby give my consent (please complete your details below)

Name …….. Date of Birth ……..

Address ……. Registered GP ……..

…….

…….

for (name of person/people to whom information may be given)

Name ……. Relationship to patient ……

Address ……. Telephone number……..

…….

Name ……. Relationship to patient ……

Address ……. Telephone number……..

…….

to be informed of all clinical information relating to me (please tick appropriate box);

Indefinitely ☐

Until (please add date) ☐ **……..**

Signed (patient) ……. Date ……..

For surgery use only:
Scanned onto patient record ……. Read coded …… Date ……
(initials) (initials)