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| DR K. BUTT  DR P. DE SILVA  DR F. FENOJO  DR J. SANDERS  DR J. SIDAWAY  DR N. NARRA  DR I. BUTT  Oakwood Surgery | **Contact Details**  Tel: 01623 435555  www.oakwoodsurgery.co.uk  nnccg.oakwood.surgery@nhs.net  Oakwood Surgery  Church Street  Mansfield Woodhouse  NG19 8BL  Bull Farm Branch  Concorde Way  Mansfield  NG19 7JZ |

**CONSENT FORM**

Consent for Carer to have access to medical records

To allow us to keep your details as a Patient Carer, we require your consent to comply with the General Data Protection Register. The information you provide to us will be entered into the computer records of the patient concerned. It will then be kept confidential and only used for the benefit of the patient.

If in the future you are no longer acting as carer, please contact us so your details can be removed.

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| PATIENT’S NAME & D.O.B. |  |
| ADDRESS |  |
| TELEPHONE CONTACT NUMBERS | HOME:  MOBILE:  WORK/BUSINESS: |

|  |  |
| --- | --- |
| CARER’S NAME & D.O.B. |  |
| ADDRESS |  |
| TELEPHONE CONTACT NUMBERS | HOME:  MOBILE:  WORK/BUSINESS: |
| RELATIONSHIP TO PATIENT: |  |
| ANY OTHER RELEVANT INFORMATION |  |
| Is the patient you are caring for a Dementia patient? | Yes  No |

SIGNED (Carer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my Carer detailed above, to have access to my medical records and personal details held by the Practice.

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| This permission relates to | all |  |
|  | part of my record |  |
|  | specific condition only |  |

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

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| Verification of Signature of Patient | Yes No Reason why not |
| Evidence of identity  i.e. Passport, driving licence plus utility bill. |  |