TUDOR HOUSE MEDICAL PRACTICE

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION TO OTHERS

Patients over the age of 13 (under UK DPA 2018) are assumed to have mental capacity to consent to third party access.

Surname: ……

First Names: ……..

NHS No. ……

Date of Birth: …………………………………………… Male/Female: ……………………………………………

I hereby give consent for Tudor House Medical Practice to discuss my medical record with:

Surname: ……

First Names: ……..

Address. ……

Tel No: …………………………………………… Relationship: ……………………………………………………..

<u>Please tick the statement(s) applicable:</u>

Full and open ended disclosure of any matter related to my medical record ☐ **OR**

Limited disclosure of the following aspects of my medical record:

Test Results ☐ Prescriptions ☐

Appointment Queries ☐ Referral Queries ☐

Any other matters related to my medical records, please state: ………………………………………

………

………

I am aware that this consent may be revoked by me at any time by confirming in writing

Signature:……………………………………………………… Date:………………………………

Name:………………………………………………………………