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| **Sharing Your Health Record** |

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| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you? [ ]  Yes *(recommended option)* [ ]  No, neverDo you consent to your GP Practice viewing your health record from other organisations that care for you? [ ]  Yes *(recommended option)* [ ]  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information? [ ]  Yes *(recommended option)* [ ]  NoDo you consent to having an Enhanced Summary Care Record with Additional Information? [ ]  Yes *(recommended option)* [ ]  No |

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| **Signature** |
| Signature of patient |  |
| Patients Full Name: |  |
| Date of birth: |  |
| Address: |  |
| Date |  |
| [ ]  Signed on behalf of patient |
| Full Name & Address |  |
| Relationship to patient |  |