**APPLICATION FOR THIRD-PARTY ACCESS TO HEALTHCARE INFORMATION**

To maintain confidence in our patients, at Thornbury Road Centre for Health we will not divulge any medical information about you unless it is legally appropriate, or we have your consent to do so.

**Who should complete this form?**

* Anyone who is competent to do so
* Children aged 13 – 15

**Agreement**

Should you wish to consent for a nominated person to be able to discuss any medical information about you with staff at this practice, please indicate this in the form overleaf.

Although by completing this form, the following should be noted:

* The person granting access to a third-party must fully complete and sign the form
* Any incorrectly completed forms will not be processed and will be returned to person making the application
* This form does not permit any third-party individual to make healthcare decisions on behalf of the named patient
* This practice may contact you via email or telephone should there be any concern

**Disclaimer:**

It is also your responsibility to keep us informed as to who can access and discuss specific areas of your medical record as detailed on the form. Should your circumstances change, it is your responsibility to advise this practice.

Thornbury Road Centre for Health relinquishes all responsibility should the above information become incorrect if not updated.

|  |
| --- |
| ***To be completed by the practice:***  Name of staff member receiving the form: …………………………………………………….  Date form received at the practice: ………………………………………………………….  Confirmation of patient’s identity: ………………………………………………………………  🞏 Patient provided photo ID  🞏 Information confirmation from medical record [I am satisfied that the patient returned this form]  🞏 Someone else returned this form on the patient’s behalf………………………………… |

I, [insert patient name] hereby give permission for Thornbury Road Centre for Health to discuss my medical records with the following:

|  |  |  |
| --- | --- | --- |
| **Patient requesting permission to allow proxy access** | | |
| **Full name** |  | |
| **Date of birth** |  | |
| **Address** |  | |
| **Signature** |  | |
| **Date** |  | |
| **Telephone/Email** |  |  |
| **Named person receiving access** | | |
| **Full name** |  | |
| **Address** |  | |
| **Telephone/Email** |  |  |
| **Relationship** |  | |

**Agreement as to what can be divulged**

I give permission for the following to be permitted or discussed with the above named person should they request (tick all that apply):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Appointments** | **Medication** | **Consultations** | **Test results** | **Referrals & Letters** |
| 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
| **Letters from other organisations** | **Text messages and e-mails** | **Whole Medical Record** | 🞏  **Other – please Specify below:** | |
| 🞏 | 🞏 | 🞏 |  | |

**How long should this agreement last?**

🞏 I want this agreement to be permanent

(I understand that I can contact the practice to end this agreement at any time)

🞏 I want this agreement to end on: ………………………………

*Please note that for 13-15 year olds, this agreement will automatically end on your 16th Birthday.*