ROTHES MEDICAL PRACTICE

Pitteuchar Health Centre
Glamis Centre
GLENROTHES, KY7 4RH

Patient Name.....(Please Print Full Name)

Date of Birth.....

Under the General Data Protection Regulations (GDPR) May 2018 I give consent for my nominee to act on my behalf:

□ Receive Test Results

□ Discuss Medication

Please tick the boxes you wish to give consent to.

Reason.....

Nominated Person..... (Please Print Full Name)

Contact Details: .....

Relationship to Patient.....

A copy of this will be held in your medical record. You can withdraw your consent at any time by contacting the Practice.

Signature.....

Date.....