Consent to Share Information Form

Patient Details	
First Name:	Surname:
Address: Telephone:	Date of Birth:

Consent to Share with		
Name:		**DoB:**
Telephone Number		
Relationship to patient		
Next of kin?	Yes No - delete as appropriate	
Emergency Contact?	Yes No - delete as appropriate	
Do you give consent for them to discuss your health record?	Yes No - delete as appropriate	
Do you have a carer or are you a carer? Yes No - delete as appropriate If yes, please complete a Carers form		

SIGNATURE of Patient	DATE

Email opt-out

We value your privacy. Your e-mail address will only be for surgery use including Practice news. Your information will never be sold or distributed to a third party. If you wish to opt out of e-mail contact please tick the box below.

I do not agree to the practice contacting me by e-mail ☐