Consent to Share Medical Information

I give permission for my GP practice to share my medical information with the representatives listed below. I reserve the right to reverse any decision at any time. I understand the risks of allowing someone else to have access to my medical information.

The Patient (This is the person whose records may be shared)

Surname		Date of Birth	
First name			
Address Postcode			
Email address			
Telephone number		Mobile number	
Signature of Patient:		Date:	

What type of information can be shared:

All	Yes ☐	No ☐
Test Results	Yes ☐	No ☐
Appointment Information	Yes ☐	No ☐
Medications	Yes ☐	No ☐
Other:	_____	

The Representatives

Surname	Surname
First name	First name
Relationship to patient	Relationship to patient
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile
Next of Kin? Y/N	Next of Kin? Y/N
Registered as Power of Attorney? Yes/No **Please note: Please provide a copy of the confirmation of Power of Attorney**	Registered as Power of Attorney? Yes/No **Please note: Please provide a copy of the confirmation of Power of Attorney**

I/we understand and agree with each of the following statements:

1. I/we will treat the patient information as confidential	☐
2. I/we will be responsible for the security of the information that I/we see or discuss	☐
3. I/we will contact the practice as soon as possible if I/we suspect that information has been shared with someone without my/our agreement	☐
4. If I/we become aware that information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	☐

Signature/s of representative/s	Date/s