Weobley & Staunton-On-Wye Surgeries

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient's Details	
Surname	
First Names	
Date of Birth	
Male / Female	
Address	
Tel No.	

By signing this form below, I give my permission to the person listed to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed compliant authorisation. This permission will be considered ongoing until I state in writing otherwise.

Details of person to be given access to this Patient's information	
Full Name	
Address	
Tel No	
Relationship	

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

Cont/over …..

The Clinician/Staff has my permission to (please tick all boxes that apply):

- ☐ Leave message at home with my spouse
- ☐ Leave message on mobile
- ☐ Leave message at work
- ☐ Leave a message on my voicemail
- ☐ Leave a detailed message on answering machine

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Your Chosen Identifer/Password	

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.	
Signature	
Date	