ALTON STREET SURGERY

Alton Street, Ross-on-Wye, HR9 5AB
Telephone 01989 563646

Advocacy Request Form

The patient (The person whose records are being accessed)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

I give permission for the person detailed overleaf to act as my advocate and be able to:

- ○ Discuss my medical record.
- ○ Discuss my test results.
- ○ Be with me during consultations.

Please tick the statement below if you agree with it:

- ○ In the event that I no longer want this advocate to access my medical information, I understand that it is my responsibility to inform the practice in writing.

Signature: _____ Date: _____
(The patient)

The advocate (The person who is speaking or writing on behalf of the patient)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

Relationship to patient: _____

Please tick all of the statements below if you agree with them:

- ○ I will keep sensitive medical information safe and secure.
- ○ I will not share any patient information that is shared with me.
- ○ I understand that the patient above has the right to cancel this access at any time.

Signature: _____ Date: _____
(The advocate)

For practice use only

Competency assessed: Yes / No

GP Name: _____

Date: _____

Alert added to patient record Yes / No

Processed by: _____