# Patient Consent Form for another person to access their medical records

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| **Patient’s Details**  **(The person whose records another individual(s) is to be given access to)** | |
| **Surname** |  |
| **First Names** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Tel No.** |  |

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| --- | --- |
| **Details of person to be given access to this Patient’s information** | |
| **Full Name** |  |
| **Address** |  |

(if more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

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

**Consent for children under 16 (Gillick Competence)**

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

**I am the Patient / Parent / Guardian (delete as necessary).**

**Signature**: ……………………………………………………………………………………………………………………………..…..

**Full Name**: …………………………………………………………………………………………………….……..………….……....

**Address (if not the same as patient):**

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