|  |  |  |
| --- | --- | --- |
|  |  | **Rushall Medical Centre** |
|  | **Tel : 01922 622212 Email: clinicalinfo.m91019@nhs.net** |
|  | **107 Lichfield Road, Rushall, Walsall, WS4 1HB****Pelsall Village Centre, High Street, Pelsall, Walsall, WS3 4LX** |

# **3rd Party Authorisation**

# **(Consent to share patient data with specified 3rd party)**

## I consent to the disclosure of information held in my medical to the third party named on this authorisation form.

## Patients ID will be required when presenting this form.

## Please indicate which statement is applicable:-

## Full Disclosure of any matter related to my medical records and treatment including but not limited to:

## Appointments - make; amend; cancel or enquire.

## Prescriptions - request; collect; discuss; past and present.

## Test Results – collect; discuss; past and present.

## Referrals, request; collect; discuss; past and present

## Update contact information, address; contact numbers.

## Discuss my medical condition / treatment / records past and present with practice staff.

##  Limited Disclosure – please tick all that apply

## Prescription queries

## Test Results

## Referral queries

## Other – please specify

|  |
| --- |
| **Patients Details**  |
| **Full Name**  |  |
| **Address** |  |
| **Post code**  |  |
| **Email address**  |  |
| **Date of Birth**  |  |
| **Home telephone** |  |
| **Mobile telephone**  |  |
| **Signature**  |  | **Date**  |  |

**I acknowledge I can revoke this authorisation at any time in the future by writing to the practice manager.**

|  |
| --- |
| **Third Party Details** |
| **Full Name**  |  |
| **Address** |  |
| **Post code**  |  |
| **Email address**  |  |
| **Relationship to patient**  |  |
| **Home telephone** |  |
| **Mobile telephone**  |  |
| **Signature**  |  | **Date**  |  |

|  |
| --- |
| **Office use Only** |
| Date Received - *Staff initials*  |  |
| Patients - ID checked – Staff Initials  | **Details** |
| Vouched for – clinicians name  |  |
| Reminder Alert added – *staff initials* - Full disclosure - Limited disclosure  |  |
| Scanned to records - *staff initials*  |  |
| Coded problem 9NdG - *staff initials* Consent given to share patient data with specified 3rd party  |  |