NHS England

Enhanced Data Sharing Model (eDSM) Patient Preference Form

Having read the information regarding your choices, please choose **one** of the options below in each sharing category and return the completed form to Billesdon Surgery:

Sharing OUT – I would like to share my medical record with other organisations that may care for me.

☐ YES, share data with other organisations.

☐ NO, do not share any data recorded at my practice.

Sharing IN – I would like my practice to view data that is recorded at other care services that may care for me, where I have agreed to make the data shareable.

☐ YES, allow my practice to view data from other organisations.

☐ NO, do not allow my practice to view data from other organisations.

Name of Patient: ……

Address: ……

Postcode: …… Date of Birth: ……

NHS Number (if known): ……

Signature: …….. Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare