Discuss my health with someone else – Consent Form

Please complete this form if you wish to grant a representative the ability to communicate with us about you and your health. Completing this form will enable the person(s) of choice to gain access to information about you and your medical problems, talk to us about your care, and give and receive information about you.

Giving consent to and for someone else to communicate with us about you and your medical problems is a very significant step and you should give it serious consideration. You need to consider what they might learn about you and your health, that you did not or may not want them to know.

By completing this form, you are advising that you have fully considered the ramifications of giving that consent. If you are unsure about giving consent, we advise that you do not give it and that you seek legal advice before processing.

About me (the patient):

Photo I.D. must be shown by the patient in person, at the time of submitting this form (except in very exceptional circumstances), to confirm that they are the patient submitting this form. This is important to demonstrate that this request is from the patient.

1. **Patient`s full name: _____**
2. **Patient`s date of birth: _____**
3. Patient's NHS Number (if known): _____
4. Patient`s contact telephone number: _____

About them (the person who will now have access):

5. **The name of the person I am giving access to** *(one form per person please)***:_____**
6. **Their relationship to me:** *e.g. Neighbour/Daughter / Friend* **_____**
7. Is this person also registered as a patient at Aire Valley Surgery themselves? Yes / No
8. Their telephone number(s): _____
9. Would you also like them recording on file as your next of kin and/or emergency contact: Yes / No

What can be shared with this person:

- ☐ To be given **test results and immunisations.**
- ☐ To be able to discuss questions about **my medication** or prescription requests
- ☐ To be able to **ask details of my appointments** – e.g., times and dates, to be able to cancel appointments and **make** appointments where necessary
- ☐ To be able to discuss any **referrals** that have been made on my behalf.
- ☐ To be able to see my medical record, be informed what I have been diagnosed with, and see my whole medical history.
- ☐ **All the above** ☐ Other (please specify):

Signed and authorised by me, the patient:

Patient`s Signature: _____ Date: _____

You <u>can</u> change your mind!
Consent may be revoked by the patient at any time, by putting this in writing to the Surgery.

This extra section only applies if a patient is not capable to consent:

If the patient is aged 13 or over, they must sign this form themselves and show photo ID to prove that this is their own request.

If a patient is incapable of giving consent, this form can be signed (above) on their behalf by someone else, providing that this representative has a legal "Lasting Power of Attorney (LPA for Health and Care Decisions" or other legal document confirming this authority and leave a copy of such legal document with the form (please never leave original copies).

Full name, address and phone number of representative who has signed this on behalf of the patient.

Patient representative full name: _____ Date of birth: _____

Address: _____

Contact number _____

Office Use: Reception staff to complete this bit

Who handed form in:

Patient? Patient representative?

What type of photo ID checked (for either the patient or their legal representative acting on their behalf):

Passport Driving Licence Other, please specify:

If this was not the patient, what proof of legal authority has also been shown?:

*Lasting Power of Attorney **for Health and Welfare** Court Appointed Deputy Legal authority e.g. "LPA for health and care decisions" SPECIFY HERE:_____*

Scanned copy of any official legal documentation shown, e.g. power of attorney must always be taken and added to the medical record in case of any future queries.

☐ *I know that this fully completed form and any legal documentation now needs to be scanned in and a task sent to workflow to add relevant codes/registration details to patient record and home screen.*

☐ *Receptionist full name: _____ / Date: _____*