



## Consent to Share Information Form

Patient Details	
First Name:	Surname:
Address:	Date of Birth:
Telephone:	

Consent to Share with	
Name:	DoB:
Telephone Number	
Relationship to patient	
Next of kin?	Yes No - delete as appropriate
Emergency Contact?	Yes No - delete as appropriate
Do you give consent for them to discuss your health record?	Yes No - delete as appropriate
<b>Do you have a carer or are you a carer?</b> Yes No - delete as appropriate If yes, please complete a Carers form	

SIGNATURE of Patient	DATE
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### Email opt-out

We value your privacy. Your e-mail address will only be for surgery use including Practice news. Your information will never be sold or distributed to a third party. If you wish to opt out of e-mail contact please tick the box below.

I do not agree to the practice contacting me by e-mail ☐