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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** |  |
| **Relationship to Patient** |  |
| **Tel No.**  |  |
| **Email 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, 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 |  |

Practice Email; stgeorges.enquiries@nhs.net

Surgery website; www.st-georgessurgery.co.uk