windrush
MEDICAL PRACTICE

Patient Consent Form

For another person to access your Medical Records

Patient's Details

The person whose records may be access by the named other individual/s)

Surname	
First names	
Date of birth	
Gender	
Address	
Telephone number/s	

Details of person who is to be given access to the above Patient's Information

Full name	
Address	
Telephone number/s	
Limits of access (where applicable)	Please detail below if the above access is to be limited in any way (eg, only for test results, or only for making and cancelling appointments, or for a specific time only).

I confirm that I give permission for the Windrush Medical Practice to communicate with the person identified above with regard to my medical records.
Signature …… **Date:** ……