CONSENT FOR OTHERS TO SPEAK ON YOUR BEHALF

Patient Name

Patient DOB

I hereby give permission for the surgery to discuss my medical records with the following people

Name	Date of Birth	Relationship to patient	Also a patient at the surgery?

I give permission for the following things to be discussed with the above people. (please tick)

Test results	
Prescriptions	
Consultations with Dr/Nurse	
Referrals	
Appointments	Post a copy
Legal matters	
Benefits matters	

Signed (by patient):

Date:

Next of Kin/Emergency Contact

Name	
Address	
Contact Number	
Relationship to you	

S:\GDPR