

TRESCOBEAS SURGERY

**Consent form**

**(for another individual to gain access and / or to discuss my medical record)**

**Patient details**

|  |  |
| --- | --- |
| **Patient name** |  |
| **Date of birth** |  |
| **Address****Postcode** |  |
| *I am a patient of Trescobeas Surgery and understand I need to give consent for another individual to have access to my medical records and/ or to discuss my medical requirements. I understand the contact details of the individual will be recorded on my medical record.***Signature of patient/ guardian:****Relationship to patient:** **Date:**  |

**Contact details for the individual who I wish to grant access**

|  |  |
| --- | --- |
| **Full name** |  |
| **Telephone number** |  |
| **Relationship to patient** |  |

I understand if any of the consent contact details change or I wish for them to be removed from my medical record I will contact the surgery immediately. A ‘remove/ change to consent form’ is available from our Reception or to download from our website. [www.trescobeas-surgery.co.uk](http://www.trescobeas-surgery.co.uk)

**(Please tick)**

***September 2020***