**CWMFELIN MEDICAL CENTRE**

**CONSENT TO SHARE INFORMATION**

**Full Patient’s Name:**

**Date of birth:**

**Address:**

I consent to the individual(s) named below to (please tick as appropriate):

* Speak to the practice about all my health needs
* Speak to the practice about my medication
* Speak to the practice about my test results
* Speak to the practice about the following specific information (please add clear instructions):

Please add the name(s) and relationship(s) of elected individuals. Please also add contact details if different to those on your record and you want the practice to be able to contact them.

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Contact Details** |
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|  |  |  |
|  |  |  |
|  |  |  |

Signed patient: ........................................................ Date........................................

If you wish to change these instructions, please contact the Practice.