|  |  |
| --- | --- |
| Patient Name:  |  |
| Date of Birth: |  |
| Address: |  |

**Consent form to disclose confidential medication information to a third party**

|  |  |
| --- | --- |
| Full name: |  |
| Date of Birth |  |
| Telephone number |  |
| Relationship to patient |  |
| Address |  |

I hereby consent to the disclosure of my confidential medical information to:

Please tick the statement/s applicable:
**Full disclosure** of any matter related to my medical record

**OR**

**Limited Disclosure** (please tick the relevant boxes below)

Test results
Appointment booking and queries
Prescription and medication queries
Referral queries
Any other matter relating to my medical record (please state)
There will be no specified end date for the consent but Thornbrook Surgery will review the list every **12 months.**I am aware that this consent may be **revoked** by me at any time, in writing to the surgery.
I understand that I will need to **provide a form of ID** to Thornbrook Surgery to give consent.

Patient Signature Date

Please tick here if the patient lacks capacity to sign and/or provide identity.

Witnessed by (not the individual for whom consent is being granted, this could be a member of staff from Thornbrook Surgery)

Name of Witness:

Signature Date

**GP/Surgery use only**
Authorisation for 3rd party consent where the patient lacks capacity and it is in the patient's best interests.
GP name:
Signature:
Date:

ID of patient checked by staff

Alert added to patients notes with staff initials and date

Staff name & date added

Code added to the patients notes (Consent given to share patient data with specified third party)

Scanned onto the patients notes