PARKLANDS SURGERY

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION TO THIRD PARTY

Patient Details	
Surname	
First Name	
Date of Birth	
Address	
Telephone Number	

Details of Person(s) you consent to access your medical information	
Person Number 1	
Full Name	
Address	
Relationship to patient	
Person Number 2	
Full Name	
Address	
Relationship to patient	

Please tick applicable statement below:

I AUTHORISE FULL ACCESS TO MY MEDICAL RECORD ☐

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I AUTHORISE LIMITED ACCESS TO INCLUDE ONLY:

TEST RESULTS ☐ PRESCRIPTION QUERIES ☐

APPOINTMENT QUERIES ☐ REFERRAL QUERIES ☐

ANY OTHER MATTER RELATED TO MY MEDICAL RECORD, PLEASE

STATE:_____

I confirm I give permission for the practice to communicate with the person(s) named above in relation to my medical records. I am aware that this consent may be revoked by me at any time.	
Full Name	
Signature	