**DAWLEY MEDICAL PRACTICE**

**PERMISSION TO INFORM NOMINEE**

This is to confirm that I give permission for my test results, appointment details etc. to be relayed to my nominee, as listed below:

|  |
| --- |
| **PATIENT DETAILS** |
| FULL NAME |  |
| DATE OF BIRTH |  |
| ADDRESS |  |
| SIGNATURE OF PATIENT |  |
| (IN THE PRESENCE OF A MEMBER OF THE PRACTICE TEAM) |
| DATE |  |

|  |
| --- |
| **DETAILS OF INFORMED RELATIVE** |
| RELATIONSHIP TO PATIENT |  |
| FULL NAME |  |
| ADDRESS |  |
| Are you a patient at our Practice? | YES |  | NO |  |
| Are you a carer for the above named patient? | YES |  | NO |  |
| If yes, please ask at reception for more details |
|  |
| **CONTACT DETAILS** |
| HOME: |  |
| MOBILE: |  |
| OTHER: (PLEASE SPECIFY) |  |

Office Use Only:

|  |  |  |  |
| --- | --- | --- | --- |
| Alert on Screen |  | Scanned |  |
| Patient Relationship screen updated |  | Filed |  |