**THIRD PARTY CONSENT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, D.O.B, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO Consent/ DO NOT consent *(circle appropriate),* to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to *(please tick relevant boxes below)*

* Speak to the surgery and exchange information on my behalf with staff.
* Discuss medical information with the GP’s.
* Have access to my Patient Services (Online account), for: *(please tick the level of access the third person can have)*
* Appointments
* Prescription
* Medical records\*\*

In relation, the third party is my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the person signing this consent, I understand that I am giving my permission for the above named to OBTAIN/ NOT OBTAIN confidential health care information. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the surgery.

Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**:

Date received: Received by:

* Consent given to leave message with a specified 3rd party: **9Ndw**
* Consent given to share patient data with a specified 3rd party: **9NdG**
* Consent withdrawn to share patient data with a specified 3rd party: **9NdJ**
* Declined consent to share patient data with a specified 3rd party: **9NdH**

Date actioned: Actioned by: