Thurso & Halkirk Medical Practice

Consent Form

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____ **TEL NO:** _____

By completing this form you are granting access to personal information that we hold on file about you, to another individual(s). You must list the name, address and telephone number of the individuals concerned in the box below.

You must also list the information you wish us to share in the "Information to be released" box below: eg: collection of prescriptions, collection of sick lines, results of tests, any information in my medical record, or any other specific information (which you would need to detail).

Individual(s) being granted access to your personal information:

Name	Address	Tel No	Signature of Representative	ID Checked (Staff Only)

Please note that representatives will need to present two forms of ID with this form (Photo ID, plus proof of their own address)

Information to be released:

By signing below, you indicate that you are the individual (patient) named above. The practice cannot accept requests regarding your personal data from anyone else, including family members. We may need to contact you for further identifying information before responding to your request. You warrant that you are the individual named and will fully indemnify us for all losses, cost and expenses if you are not. *We will check signatures against any we hold on file. It may be necessary for you to attend with photo ID and proof of your address.*

PATIENT SIGNATURE: _____

DATE: _____

NOTE: You may withdraw this consent at any time. It is important that you let us know immediately if you wish to do so