PATIENT CONSENT FORM

CONSENT FOR REPRESENTATIVE/S TO ACCESS TEST RESULTS ON PATIENT'S BEHALF

PATIENT

NAME_____ DATE OF BIRTH * _____

ADDRESS _____

_____POSTCODE _____

GP NAME _____

REPRESENTATIVE/S

I understand that I will only have access to results **IF** the above patient grants consent.

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

DECLARATION OF CONSENT

I hereby give consent for the above named representative/s to access test results on my behalf.

I understand I can revoke this authority at any time by contacting the surgery.

***I am under 18 years of age. I authorise my representative/s to gain information on my behalf. I understand this consent form will no longer be valid once I turn 18 years of age, at which point a new consent form should be completed if required.** ☐

***I am over 18 years of age. I authorise my representative/s to gain information on my behalf.** ☐

SIGNED _____ DATE _____