

# WHITE MEDICAL GROUP

## Consent form from patient allowing practice staff to share information from medical record with a named third party

This section should be completed by the patient. Complete all shaded areas

I (please print your name)

Date of Birth:

Address:

Request that the following person:

Address:

Date of Birth:

Telephone no:

Relationship of this person to myself  
(eg husband / wife, son / daughter)

### Level of information you would like to be shared with the above (please tick):

- Whole medical record. If so, you MUST specify from the dates below
- Specific parts of medical record for example only information relating to diabetic care, please detail \_\_\_\_\_
- Details of appointments made (specify if all appts or only those made in practice)
- Documents from the practice to the patient e.g. letters with results or appt invites
- Documents with clinical information from third parties, eg hospital letters
- Results (specify if all results, or some results e.g. just x-ray or just blood results)

### What dates would you want this to apply to:

- All past and future dates      **or**       From \_\_\_\_\_ To: \_\_\_\_\_ .

Signature of  
**patient:**

Date: