# Gamston Medical Centre

## Patient Consent Form
## for another person to access their medical records

| **Patient's Details**<br>**(The person whose records another individual(s) is to be given access to)** | |
|---|---|
| **Surname** | |
| **First Names** | |
| **Date of Birth** | |
| **Male / Female** | |
| **Address** | |
| **Tel No.** | |

| **Details of person to be given access to this Patient's information** | |
|---|---|
| **Full Name** | |
| **Address** | |
| **Tel No.** | |
| **Relationship to Patient** | |

(if more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

| **Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)** |
|---|
| |

| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.** | |
|---|---|
| Signature | |
| Date | |