Minchinhampton Surgery
Patient consent to share information with a third-party

About

To maintain patient confidentiality, Minchinhampton Surgery will not divulge any medical information unless deemed legally appropriate or we have your consent to do so. If you wish to consent for a nominated third party person to be able to discuss any medical information about you with staff at this practice, please return this completed form to reception.

It is your responsibility to keep us informed as to who can access and discuss specific areas of your medical record as detailed on this form. Should your circumstances change, it is your responsibility to inform the practice

Patient details

Full name:	
Date of birth:	
Address:	
Contact number:	
NHS number:	

Patient declaration

I give permission for the below named third-party to have access to my personal details and medical record held by the practice. I understand that this permission will remain in force until cancelled by me in writing and that the doctor may override this authority at any time. I confirm that my GP has sole discretion to withhold any or all copies of correspondence.

Signature*:	
Date:	

*Signature not required if patient is under 13 years old or lacks capacity to consent

Level of permission (please tick ONE only)

I give permission for access to **ALL OF** my personal details and medical record held by the practice	☐
I give permission for access to **PART OF*** my personal details and medical record held by the practice	☐

*If you would like your named third-party person to only have partial access to your medical record, please tick below exactly what access is allowed:

Discussing appointments	☐
Discussing medication	☐
Discussing test results	☐
Discussing referrals	☐
Discussing your health conditions	☐

Third party details

Full name:	
Date of birth:	
Address:	
Contact number:	
NHS number:	
Relationship to patient:	

Third party declaration

I will be responsible for the security of the information shared with me. I will treat all information confidentially and I will not disclose this information to any other third party without the express permission of the patient. I will only use this information in the best interests of the patient.

Signature:	
Date:	

For practice use only

I authorise the above third-party person to have access to the personal details and medical record held by the practice for the above patient. The patient does / does not (please delete as applicable) have capacity to consent.

Date received:	
Reviewed by:	(Usual GP)
Review date:	
Action (delete as applicable):	Approved / Refused
Date form scanned:	
Date reminder added to patient record:	
Date reminder added to third party record:	