Pembroke Surgery K81100 Consent to Share Information with a Carer/Relative

PATIENT DETAILS		CARER/ RELATIVE DETAILS	
Name		Name	
Address		Address	
Post Code		Post Code	
Telephone		Telephone	
E-Mail		E-Mail	
Mobile		Mobile	
Date of Birth		Relationship to patient	

I give permission for my relative/carer to have access to my medical records and personal details held by the Practice and for staff to discuss this with my relative/carer.

This permission relates to all / part of my records. (Delete as appropriate)
Where permission is restricted to part of the records only the areas included are:

Specific exclusions are:

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records at any time.

Signed.. (Patient)

Date...

I will treat any information provided confidentially , I will not disclose information to a third party without agreement and will only use the information in the person that I care for's best interest.

Signed... (Carer/relative)

Date..