BILLERICAY MEDICAL PRACTICE

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Consent Form for Release of Information to a Third Party

I (insert name of patient/recipient of care)

……DOB……

Of (insert address of patient/recipient of care)

……

……

Do hereby give my consent for (insert name of person acting on your behalf)

……DOB……

Of (insert address of person acting on your behalf)

……

……Tel No……

To request information regarding my medical history/results/or any other relevant information held by the surgery.

I understand that the information released under this authority may include both clinical and non-clinical information relating directly to me.

Signed……Date……..
(If the named Patient is not able to sign for themselves, then please phone reception for further advice).