**CONSENT TO ACCESS TO MEDICAL RECORDS BY THIRD PARTY**

**Details of the PATIENT Authorising Access:**

|  |  |
| --- | --- |
| Surname | NHS Number |
| Forename(s) | Address |
| Date of Birth |
| Telephone Number |

**Details of the AUTHORISED Person:**

|  |  |
| --- | --- |
| Surname |  |
| Forename(s): |  |
| Address: |  |
| Telephone Number: |  |
| Relationship to Patient: |  |

**Declaration: I declare that the information given by me is correct to the best of my knowledge and that I give the authorised person access to my medical information in the following statements.**

Tick of the following statements that apply.

* Discuss test results
* Discuss medical conditions relating to a current illness
* Discuss medical conditions relating to any illness
* Discuss my full medical records

YOUR SIGNATURE………………………….. DATE…………………….

Completed forms to be scanned and filed.

**Authorisation of Consent to share of patient data**

I hereby give consent for my spouse/partner/son/daughter/friend/other …………………………………... (delete as appropriate) authorisation to my medical information. **Please complete both sections**.

**Section A with name of authorising person.**

**Section B with name of patient.**

***Section A***

Name:……………………………………………………………………………………………………………….. (Block capitals)

Address:………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………….

DOB:……………………………………. to have access to the following information:

Test results YES/NO

Scan results YES/NO

X-ray results YES/NO

Consultation YES/NO not sure about this line

***Section B***

Name:……………………………………………………………………………………………………………….. (Block capitals)

Address:………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………….

DOB: …………………………………….

If at any time in the future I wish to reverse this decision I will notify the surgery in writing.

Please provide a brief description for the reason the information is to be shared.

…………………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………….

This document will be scanned in to the patient computerised medical record and filed in the patient MRE.

Signed: ……………………………………… Date:……………………………….

**To be completed by surgery**

**Date received: …………… Date actioned: ………… Staff initial: ……………..**