FRESHWELL HEALTH CENTRE

CONSENT TO SHARE INFORMATION

Patient Name		**Date of Birth**	

I give my consent for the surgery to share the following information:		
☐	My full record and all aspects of my care	
☐	Only my test results	
☐	Other information only (please specify)	

With the named person(s) below:			
Name		**Relationship to patient**	
Address		Phone	
Name		**Relationship to patient**	
Address		Phone	
Name		**Relationship to patient**	
Address		Phone	

These instructions are valid from:			
Today's date		until	
(please specify end date). If none specified, the Surgery will accept this as a permanent instruction			

Signature		Date	
Name (if signed on behalf of patient)		Relationship to patient	

If signed of behalf of patient, please state reason, eg parental responsibility or the patient lacks mental capacity