Pen Y Bont Surgery
Consent to Share Information with a Carer/Relative

Patient Details		Relative/Carer Details	
Name:		Name:	
Date of Birth:		Relationship to patient:	
Address:		Address:	
Post Code:		Post Code:	
Telephone:		Telephone:	
Mobile:		Mobile:	

By completing this form you are giving permission for a chosen relative/carer to have access to your medical records and personal details held by the Practice and for staff to discuss my health records and results with my relative/carer as detailed below. This can be amended at any time and you are able to stop the access at any time by notifying the practice.

This permission relates to (please select those appropriate)

☐ Obtaining test results on my behalf

☐ Part of my records

☐ All of my medical records

Time Scale (please indicate)

☐ Set time period: From______________________ To______________________

☐ Ongoing/no end date

Where permission is only for a set time scale or restricted to part of the records for example for test results only, please give any details of specific exclusions:

I understand that this consent will remain in force indefinitely unless an end date to the consent is provided to the practice or I contact the practice to advise any differently. However, my doctor may, at my request, override this authority to allow access to my medical records at any time.

Signed.. (Patient)

Date..

PLEASE TURN OVER

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 best interest of the person that I care for.

Signed... (Carer/Relative)

Date...

Agreement to the sharing or information

Doctor...

Signed... (Partner)

Date...