|  |  |
| --- | --- |
| **Patient’s Details**  **(The person whose records another individual(s) is to be given access to)** | |
| **Surname** |  |
| **First Names** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Tel No.** |  |

|  |  |
| --- | --- |
| **Details of person to be given access to this Patient’s information** | |
| Full name |  |
| Address |  |
| Relationship to Patient |  |

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

|  |
| --- |
| **Please detail below if the above access is to be limited in any way (e.g. only for test results, only for making & Cancelling appointments or for a specified time period only)** |
|  |

|  |  |
| --- | --- |
| I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records. | |
| Signature |  |
| Date |  |

Practice Email; [stgeorges.enquiries@nhs.net](mailto:stgeorges.enquiries@nhs.net)

Surgery website; www.st-georgessurgery.co.uk