

## BIRCHWOOD SURGERY

### Consent to allow access to medical information for a third-party

*Please complete this form if you wish to grant a representative the ability to communicate with us about you. This will enable them to gain information about you and your medical problems, talk to us about your care, and give and receive information about you. It will not entitle them to order copies of your medical records, sign consent on your behalf, withdraw care or sign an order to prevent your resuscitation.*

*Giving consent to someone else to communicate with us about you and your medical problems is a **very significant step** and you should give it **serious consideration** before you give consent. You need to consider what they might learn about you and your problems that you did not want them to know and have **fully considered** the ramifications of giving that consent. Once they learn information about you, they might also share it with others that you did not intend to have that information. If you are unsure about giving consent, we advise that you do not give it and that you seek legal advice before proceeding.*

#### **YOUR DETAILS**

Full name: .....

Date of birth: ..... NHS No (if known): .....

Address: .....

.....

Mobile: ..... Home: .....

Work: ..... Email: .....

#### **YOUR REPRESENTATIVE'S DETAILS**

Full name: .....

Address: .....

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Mobile: ..... Home: .....

Work: ..... Email: .....

Their relationship to you (*delete as appropriate*):

- Parent
- Wife/Husband/Civil partner
- Son/Daughter
- Other (please state relationship):

**Extent of consent**

We need to know what problems you wish to give consent for the third-party to communicate with us about. You must specify the problem(s) for which you are giving consent. You **cannot** state 'everything' or 'all problems'.

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**Duration of consent**

This consent will be valid indefinitely.  
If you wish your consent to last for a shorter period of time, Please ensure you contact the surgery to have the consent removed from your records.

**Declaration**

I consent to the release of confidential information from my medical record as stated in this form to the person stated above

Signed: ..... Dated: .....

**Witness (please ask another adult, other than your representative, to witness your consent)**

Witness full name: .....

Witness address: .....

Witness signature: ..... Dated: .....