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|  | **PATIENT CONSENT FORM**  This form is to express your consent for another person to gain access and to, and to discuss your medical record. |

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| **Patient details** | |
| **Patient name** |  |
| **Patient's date-of-birth** |  |
| **Address (incl. Postcode)** |  |
| *I am a patient of Bewick Crescent Surgery and I need to give consent for another individual to have access to my medical record and to discuss my medical requirements. I understand the contact details of the individual will be recorded on my medical record. I also understand if any Over the consent contact details change or I wish for them to be removed from my medical record I will contact the surgery immediately. A 'Remove or Change' form is available from our reception all to download from our website at* [*https://www.bewickcrescentsurgery.nhs.uk/*](https://www.bewickcrescentsurgery.nhs.uk/)  **Signature of patient / guardian:**  **Date:** | |

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| **Contact details for the person I wish to grant access:** | |
| **Full name** |  |
| **Address (incl. postcode).** |  |
| **Contact telephone number** |  |
| **Relationship to patient** |  |