Chilcote
Surgery

PERMISSION TO SHARE INFORMATION

Patient's Name.....

Address.....

.....

Telephone.....

I give permission for the following person(s) to have access to my medical details, including results, prescriptions and consultation details.

Persons to whom your medical details may be disclosed.

Name.....

Address.....

.....

Telephone.....

Relationship.....

_____

Name.....

Address.....

.....

Telephone.....

Relationship.....

I understand that this authorisation will remain in effect until I give written notice to remove any of the persons listed above.

Signature.....

Date .....

Are you a Carer and would you like to be contacted by the Care Support Worker YES/NO