Swan And Forest Surgeries

Consent to Share Medical Records

**I,……..(Full name)**

**Date of Birth……..NHS No……..**

**Patient signature……Date……**

**Hereby give permission for the following person(s) to have access to all confidential data and information held by the surgery regarding my health, wellbeing and appointments**

Name……..

Address……..

……

Contact Tel……..

Relationship to patient……..

Name……..

Address……..

……

Contact Tel……..

Relationship to patient……..

I understand that I am responsible for amending this consent with the surgery if my circumstances change or I wish to revoke consent ☐

**Patient signature……** **Date……..**

**Preferred Method of Contact**

Please inform us of your preferred method of contact by circling your choice below:

LETTER EMAIL SMS NO COMMUNICATION