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 content. Once thy 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 seek legal advice before proceeding.

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| Your Representatives Details |
| Name: |
| Address: |
| Mobile: |
| Home: |
| Email: |
| Their Relationship to you is: |

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| --- |
| Your Details |
| Name: |
| Date of Birth: |
| NHS No (if known): |
| Address: |
| Mobile: |
| Home: |
| Email: |

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| Extent of Consent |
| We need to know what problems/service 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:[ ]  Appointment management.[ ]  Prescription management[ ]  Laboratory results[ ]  Discuss current medical needs: please advise regarding which condition ……………………………………………………………..[ ]  Referral regarding ……………………………………………………………………[ ]  Full access to my medical records from (please advise of date): …………………………………………………..[ ]  Other: ……………………………………………………………………………………………………………………………………………………………………Please list any conditions or parts of your medical records you **do not wish** the nominated person to be given access to: |
| Duration of Consent |
| This consent will be valid for either up to one year from signing or until the above problems resolve (whichever occurs sooner). If you wish your consent to last for a shorter period of time than this, please specify an earlier end date for your consent: |
| Declaration |
| I consent to the release of confidential information from my medical records as stated in this form, to the person stated above. I will advise of any Signed: Date: |
| Witness (member of Abbottswood will contact you to verify this consent) |
| Witness Name, signature and date: |