LONG STRATTON MEDICAL PARTNERSHIP

Patient Consent Form

"The practice has a responsibility and duty of care to respect and maintain patient confidentiality at all times."

We will only give information regarding the medical records of any patient if we have consent from the patient in writing. Verbal consent cannot be accepted. If you wish to allow a member of your family or friend to ring on your behalf please complete this form and hand in to Reception.

Patient Details	
Full Name	
Date of Birth	
Address	
Telephone Number	

Please accept this written consent for the following person/people to be given details from my medical records on my behalf:

	Person Number 1		***Person Number 2***
Full Name			
Date of Birth			
Address			
Telephone Number			
Relationship e.g. Daughter/Son/Friend			

Please Note: This consent does not allow the named contacts above to view or obtain copies of your medical record.

Patient's Signature…………………………………………

Date……………………………………………………………