

CONSENT TO SHARE INFORMATION

Patient Name	
Patient Date of Birth	

I give my consent for the surgery to share the following information:		
<input type="checkbox"/>	My full record and all aspects of my care	
<input type="checkbox"/>	Only my test results	
<input type="checkbox"/>	One specific recent result (please specify)	
<input type="checkbox"/>	Other information only (please specify)	

With the named person(s) below:			
Name		Relationship to patient	
Address		Phone	
Name		Relationship to patient	
Address		Phone	
Name		Relationship to patient	
Address		Phone	

These instructions are valid from:			
Today's date		until	
(please specify end date). If none specified, the Surgery will accept this as a permanent instruction			

Signature		Date	
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