HEDINGHAM MEDICAL CENTRE

CONSENT TO SHARE INFORMATION

Patient Name	
Patient Date of Birth	

I give my consent for the surgery to share the following information:		
☐	My full record and all aspects of my care	
☐	Only my test results	
☐	One specific recent result (please specify)	
☐	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		
This form msut be signed in the presence of a staff member			Staff Initials	