****

**CONSENT TO SHARE MY**

**MEDICAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| **I** | |  |
| **Of** | |  |
| **D.O.B.:** | |  |
| **Telephone:** | |  |
| **give my consent for:**   |  |  |  | | --- | --- | --- | | **Name** | **Relationship to Patient** | **Contact Details** | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   **To access/discuss:**  Appointments  Medication  Results  Recent consultations  Letter from other care providers (eg hospitals)  **OR:**  All of the above | | |
| I understand that this consent will remain in place, until I give written notification otherwise. | | |
| Signed: |  | |
| Date: |  | |

**Please return this form to Church Walk Surgery**