

**PATIENT CONSENT FORM ALLOWING ACCESS TO PERSONAL DETAILS  
and/or COPIES OF CORRESPONDANCE**

PATIENTS NAME:	
PATIENTS ADDRESS:	
PATIENTS TEL NO:	

Dear Giffords Surgery,  
I give my permission for the below named person(s) to have access to my medical records and personal details which are held by the practice.

NAME:		RELATIONSHIP:
ADDRESS:		
TEL NO:		

This permission relates to the following:

Please also confirm all which is applicable below by ticking what you are granting access for:

APPOINTMENTS  TEST RESULTS  CONSULTATIONS

PRESCRIPTIONS  FULL ACCESS

Access to consultations means that information may include childhood illnesses, women's health (Inc. smear results) and contraceptive information.

Full access to medical records means that you are permitting the above to have access to your entire medical history from birth. This will include travel information, and smear history for women. This means access to your entire medical records from birth including information relating to travel vaccinations, smear history for women, childhood information.

Where permission is restricted to part of the record or a specific condition, please specify below the precise limits of this permission, including any areas of the record which must (if any) be excluded.

I understand that my GP may override this authority at any time, and that this permission will remain in force until cancelled by me in writing and will be reviewed every 12months.

I consent to my above named person receiving copies of all correspondence relating to my treatment   
I can confirm that this has been explained to me by GP practice and that the GP has sole discretion to withhold all, or any, copies.

Signed Patient  Date

Signed GP  Date