**CARNON DOWNS SURGERY**

**THIRD PARTY SHARING OF PATIENT DATA CONSENT FORM**

**DETAILS OF THE PATIENT:**

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address |  |
| Telephone Number |  |
| **GP** |  |

All patient information is confidential. However, optional consent can be given by the patient for information to be shared with a named third party - husband, partner, daughter etc.

**I am happy for the following information to be shared with my named third party as detailed on the next page and this permission will remain in force until cancelled by me in writing**

I consent to my named person being recorded on my medical records **YES / NO**

I consent that this person may request and/or collect my repeat prescriptions and test results **YES / NO**

I consent to information about my health being discussed with the person named on this form **YES / NO**

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# YOUR DETAILS (THIRD PARTY):

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address  (If Different From Above) |  |
| Telephone Number  (If Different From Above) |  |

**I give consent to be added to the patients’ health record and will keep all information shared with me confidential.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(third party) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Office use only:** | STAFF MEMBER | DATE ADDED |
| POP UP NOTE AND READCODE ADDED TO PATIENT RECORDS **#9NdG** |  |  |

DJ/AH 19.4.18